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AN INTERDISCIPLINARY JOURNAL FOR THE PROFESSIONS SERVING CHILDREN

Positive Uses of Hospitalization

Hope for the Epileptic Child

Why So Few Negro Adoptions?

Homemaker Service in Neglect, Abuse



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LOSE HUMAN CONTACT, a prime need of all babies, is here provided to a sick child by a student nurse. How a hospital in Boston attempts to help

children not only to cope with the crises of hospitalization but also to derive emotional strength from the experience is described in the article on pages 3-8.

Milton F. Shore (right) is now with the mental health study center at the National Institute of Mental Health. His collaborators, Robert L. Geiser and Harold M. Wolman, are still at the Tufts New England Medical Center. Dr. Geiser also serves as psychologist at the Robbins Speech and Hearing Clinic of Emerson College; and Dr. Wolman as chief psychiatrist at James Jackson Putnam Children's Center.



Dr. Samuel Livingston, who has devoted his entire medical career to epilepsy, became a member of the epilepsy clinic of the Johns Hopkins Hospital in 1936, and the clinic's head in 1946. He is the author of over 100 articles on various aspects of convulsive disorders and three textbooks: "The Diagnosis and Treatment of Convulsive Disorders in Children," "Living With Epileptic Seizures," and "Drug Therapy for Epilepsy in Children and Adults."



Elizabeth Herzog (left) was with the Jewish Family Service, New York, before joining the Children's Bureau in 1954. She has written several books on anthropological subjects and numerous articles on the research needs in social work. Rose Bernstein (right), who has worked with unmarried mothers in New York and Boston, is now director of the Community Shelter Care Project in Boston.



After receiving his M.A. in social service from the University of Chicago in 1949, Aaron Seidman was a caseworker for 3 years with the Jewish Children's Bureau of Chicago, and then for 4 years with the Association for Jewish Children of Philadelphia. He returned to the Chicago agency in 1956 in the capacity of a supervisor-therapist.



Both Louise Foresman (left) and Elizabeth A. Stringer (right) studied at the University of Chicago School of Social Service Administration. Mrs. Foresman served as a child welfare worker in Nebraska and a medical social worker in Colorado before joining the Missouri agency. Miss Stringer used to work with the Australian Red Cross.



In his capacity as chairman of the U.S. Committee of the International Conference on Social Work, Charles I. Schottland was intimately involved in preparations for last summer's conference in Greece. He is a former Commissioner of Social Security (1954-58) and a one-time member of the staff of the Children's Bureau (1941-42).



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CONSTRUCTIVE USES OF A HOSPITAL EXPERIENCE

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N THE PAST DECADE pediatricians and others who serve children have become increasingly concerned with the effects of hospitalization for physical conditions upon the mental health of children. This concern has been reflected in books by John Bowlby¹ and Emma Plank;² in articles by William Langford,³ Lucie Jessner and Samuel Kaplan,⁴ and Dane Prugh;⁵ and in recent films by James Robertson⁶ in Britain, and Edward Mason⁷ in this country.

With the growing recognition of the possible traumatic effects of hospitalization, pediatric hospitals are making increased efforts to attend to the mental health of their reluctant charges. Many sources have suggested changes in hospital procedures, administrative structure, and emotional climate to prevent or lessen the traumatic effects. Some examples: preparing the child for the hospital and for elective surgery; rooming in for the mothers of children under 5; bringing along the favorite toy; liberalized visiting hours; playrooms for ambulatory children; urging parents to be present when the child awakens from surgery; and helping children act out their operations or express their feelings.

At the Boston Floating Hospital, we noticed that for some children hospitalization was a constructive experience which seemed to facilitate rather than impair their growth. Some children thrived in the hospital and became upset only at the time of discharge. Other children, during the diagnostic workup and prior to any medical treatment, showed a diminution or even complete absence of the physical symptoms, such as abdominal pain, which led to their hospitalization. (The diagnostic and therapeutic implications of this have been noted by Paul Laybourne and Herbert Miller.⁸) Still other children showed marked psychological improvement without any conscious effort on the part of the staff. These cases caused us to wonder how the hospital could be of emotional benefit to more children.

A concern for the welfare of the total child requires not only preventing and neutralizing the possible traumatic effects of hospitalization, but also trying to discharge children from the hospital in a stronger condition, emotionally as well as physically. The child needs to be helped to develop effective mechanisms to cope with the crisis of hospitalization.

The Boston Floating Hospital is an 80-bed in-patient, general pediatric unit of the Tufts New England Medical Center. It was among the first pediatric hospitals in the country to establish a playroom as part of its facilities.^{9, 10} At present, the playroom is staffed by four full-time, trained nursery

Based on a paper prepared as background for a workshop at the 1964 annual meeting of the American Orthopsychiatric Association.



The director of the playroom at the Boston Floating Hospital helps fill the gap for three young children temporarily deprived of their parents' emotional support.

school teachers and is administratively part of the hospital's child psychiatry unit.

One important aspect of a constructive emotional climate for the hospitalized child is the opportunity to satisfy basic emotional needs through close relationships with one or more persons in the hospital. Bringing this about usually requires knowledge on the part of the staff of the psychological development and needs of children of various ages. Sensitive personnel may make appropriate responses to children on an intuitive basis; however, deeper understanding makes available to them a wider range of appropriate reactions.

The recognition of children's needs for close human contact has led many pediatric hospitals to encourage nurses caring for infants to hold and cuddle them whenever possible, especially at feeding times. The importance of cuddling seems obvious in the case of infants, but it can be equally important for older children, and most important for deprived and regressed children. At the Boston Floating Hospital, the most striking examples of the need for an intense mothering relationship are seen in children admitted for medical evaluation who have had a long history of emotional deprivation. In these cases, one teacher from the playroom staff is assigned to give the child special attention. The results of this consistent and intensive mothering are often dramatic, as in Arthur's case:

Arthur was 2 years old when he came to the hospital for medical evaluation prior to placement in his fourth foster

home. At admission, he showed little affect, was withdrawn and did not speak. There were no positive physical findings but there was some suspicion of mental retardation. Formal psychological testing was not possible because of the child's limited responsiveness. One nursery school teacher gave Arthur special mothering during his 2 months in the hospital.

For the first few weeks Arthur clung to his teacher. He looked extremely apprehensive, whimpered often, frequently cringed when others came near, curled up on the floor, and sucked his thumb. The teacher held Arthur, cuddled him, talked to him, fed and bathed him, changed his diapers, and generally met his regressive dependency needs. After a while Arthur, despite marked ambivalence, slowly developed an intense relationship. He began to smile when his teacher appeared in the morning and to show signs of distress when she absented herself for even a few moments.

Over the 2-month period the change in Arthur seemed like a condensed version of a child's development during the first 2 years of life. He began to walk about, attempted to feed himself, and regained control over his bowels and bladder. He began to play with toys and engage in activities more appropriate to his age. Finally, he began to babble and then to speak single words. This was quickly followed by echo-like phrases and finally sentences. Psychological testing shortly before discharge showed him to be functioning in the average range of intelligence.

Arthur's new foster parents came to the hospital a week before his discharge. They had observed him in the playroom and were introduced to him by his teacher, who had been preparing him for this event. In repeated and longer visits the child and foster parents became familiar with each other. The foster parents talked with Arthur's playroom teacher, who discussed his background, special needs, and the problems they might encounter, and passed along suggestions on how to manage him in difficult times. By using her relationship with the child, the playroom teacher thus was able to effect the transfer of the child to his new home with minimal signs of disturbance on Arthur's part.

When Arthur left with his new parents, he was smiling, interested, and talkative, in contrast to his regressed behavior on admission. Realizing how many times he had been hurt by the pain of separation, the hospital helped Arthur to see how others could understand and support his efforts to deal with separation.

The emotional climate created in the playroom extended when necessary to otherwise normal children who are, during hospitalization, experiencing the temporary deprivation of their parents' emotional support. This same mothering approach has also proved effective in other, more subtle, cases of maternal deprivation. In the nursery, for example, children who fail to thrive because of vomiting or refusing to eat, due to tensions in the mother-child relationship, frequently become voracious eaters when mothered consistently by one nurse.

In all situations, the personnel operate on a realistic level consistent with their training as nurses and educators. No attempt is made to encourage catharsis, to work out unconscious conflicts or promote insights

ough the staff is alert to fears and anxieties and assures the children when necessary. The playroom staff provides valuable diagnostic information and also meets the emotional needs of children for contact with understanding and accepting persons. This occurs in an atmosphere consciously created to contrast with the severe restrictions of other aspects of hospital life. Frequently what is done is only the first step in a long process of emotional rehabilitation. Arthur's foster parents have to continue the job the hospital began. Even then one wonders how completely this child can overcome psychic scars left by the severe deprivations he suffered at a critical age. In many cases, followup is necessary and the psychiatric department may work a long time with the family to attempt to alter patterns of parent-child interaction.

Inconsuming Normal Growth Patterns

Some children come to the hospital from homes in which their efforts to grow are being thwarted. Sometimes parents are overprotective and keep their children dependent upon them. Other parents react to their child's growth as if it were a competitive situation, threatening their status. Still other parents, having had emotional difficulties themselves as children during a specific stage of psychological development, are unable to tolerate their own child's entering that same developmental phase. When the emotional climate of the hospital permits children to express themselves, this is often enough to unleash the psychological forces that push toward growth.

Jane, aged 13, was admitted following ingestion of poison in a suicide attempt after running away from her foster home. She had got along well with her foster mother for several years but, at the onset of adolescence, began to exhibit difficulties. Jane's natural mother had deserted her when she was 12 and because of this loss Jane had developed a self-image of needy, inadequate girl who had nothing to offer. Her foster mother, threatened by Jane's developing femininity and needing to keep Jane dependent, encouraged this image.

When Jane entered the hospital she was exactly as her foster mother had described her: sullen, argumentative, irritable, noncooperative, and belligerent. Understanding some of her background and recognizing normal adolescent strivings, the hospital staff provided her with constructive opportunities for adolescent expression.

Noticing her talent for caring for young children, the playroom staff made Jane feel as though she were an assistant teacher and taught her to care for other children. She was given a new hairdo and some bright, stylish clothes, reinforcing her tendency toward feminine adolescent behavior. Her self-worth was heightened, although basic problems were not and could not be worked through.

Jane responded almost instantly to all this. She blossomed with new importance and dignity. She became cheerful,

friendly, helpful, and talkative. She related warmly to the female playroom staff who supported her wish to grow up, and eventually she talked with a psychiatrist. The hospital recommended to the social agency that Jane not be returned to her foster home. Arrangements were made to place her in a new setting that would continue to encourage the growth the hospital had initiated.

It was extremely difficult for Jane to leave the hospital, and she expressed strong wishes to stay on. She had developed an intense attachment to the hospital and said she wanted to become a nurse after finishing high school.

Altering Parent-Child Relationships

Most children who come to the Boston Floating Hospital do so because they are physically ill. Once the child is hospitalized, however, serious concomitant emotional aspects are often discovered which complicate the hospitalization. The behavior of parent and child during visiting hours, in wards, or in playroom, may indicate to an alert staff member that a problem or even a pathological relationship exists. The more time a mother and child spend together the more accurate can the assessment of their relationship be.

The pediatric hospitals that allow a mother to live in with her ill child greatly increase the staff's opportunities to observe the mother-child relationship and increase the mother-staff contacts. Sometimes this increased contact can be helpful—when the mother feeds, watches, and comforts the child, or helps another mother. Sometimes it can upset the staff, disrupt the child's medical treatment, and cause serious management problems—when the mother is overly worried, too controlling, overly protective, or excessively suspicious. An especially difficult mother can embitter the staff's opinion of the living-in arrangement. Such cases, especially with mothers of older children, may signal a problem in the parent-child relationship or a disturbance in the parent alone. If the staff cannot deal effectively with such a mother, the child himself may feel helpless and be caught between the expectations of parent and staff.

The hospital can view such a situation not as a nuisance and an irritation but as an opportunity to attempt to alter a problem parent-child relationship. Not only can it encourage emotional growth, but it can also actively refuse to support growth-defeating interactions. Sometimes all it can do is to present reality and impose limits. At other times, it can evaluate the situation and actively try to bring about changes.

Mary, 12 years old, had a serious, though not immediately dangerous, illness. Her mother insisted on living in and very quickly alienated the staff. She refused to let the physicians

and nurses near Mary until they explained every detail of what they were going to do. She questioned every staff decision. The child refused to eat unless spooned by the mother and wept bitterly whenever the mother was out of her sight. The mother made such gloomy pronouncements in the child's presence as: "Mary is ready to meet her Maker." Mary was terrified and did not respond to treatment. The staff seemed helpless in dealing with this mother and, in despair and anger, asked for a psychiatric consultation.

Meanwhile, Mary developed a fever and was transferred to a contagious ward as a precaution. The new nurse saw the pathology in this relationship and felt a separation could be effected. This ward had no facilities for living in and the nurse informed the mother that she would have to go home. She also imposed a limit of a 1-hour visit per day. She told the child she was perfectly capable of doing things for herself. Parent and child protested, but the nurse stood firm and the mother left. Within a few days the girl was feeding herself, smiling, and acting more like a normal adolescent. Her physical improvement was rapid. The hospital's social service department guided the mother to a social agency to arrange for Mary's convalescent care.

We do not know whether the change in this mother-child relationship is permanent, but when discharged Mary and her mother were getting along better, even though the visiting hours had been liberalized. The important thing is that this mother and child changed their behavior to conform to the staff's wishes once limits were set. The hospital did not accept, and thus maintain, a problem relationship between parent and child.

Refuge From an Emotional Storm

We usually think of a hospitalized child as being torn away suddenly from a secure and stable home environment and thrust into a new and frightening world. Sometimes the reverse is true. John Rose and Meyer Sonis¹¹ have observed that the hospital can be a refuge from an intolerable home situation. It may be a relatively stress-free environment—a haven for the child while the disturbing home situation is being evaluated and resolved by the social service department. If the hospital staff accepts the child as he is, and makes demands that are consistent with his ability to respond, he can visibly change after a few days. In these cases, presenting symptoms often disappear, sometimes to reappear on the day of discharge.

Fred, aged 10, was admitted for evaluation of possible brain injury. He was actively hallucinating. Subsequent medical workup revealed no organic pathology or physical illness. The psychiatric evaluation revealed a bizarre home situation with a borderline psychotic mother. The home was in a constant state of tension, with much sexual and aggressive acting out. Both parents said they were unable to control Fred.

Fred received no active treatment in the hospital. The focus was on the demands of reality. His hallucinations

quickly disappeared, his anxiety level dropped; and he presented no management problem on the ward. Meanwhile the psychiatric team worked with the parents. When Fred was discharged, outpatient psychiatric treatment was instituted for the family. The hospital's intervention and support helped to reduce the tension in the home to a point where the returned child could experience no regressive symptoms. Continued psychiatric care by the hospital's outpatient unit was lengthy, but a possible psychiatric hospitalization or foster home placement was avoided.

Accepting the idea of the hospital as a refuge has a very important consequence: It means that sometimes a child may be detained in the hospital for therapeutic reasons after completion of the diagnostic workup and medical treatment. The hospital's emotional climate may be a healing force; though physically able to be discharged, a child may need emotional convalescence. Fred, found to have no organic pathology, could have been discharged. But discharge was delayed until the psychiatric team felt the family could tolerate his return—a matter of a week. The emotional consequences of a premature discharge could have been disastrous.

Opportunities for Identification

The hospital's emotional climate can be such that both parents and children can learn patterns of mothering through identification with staff members. Jane's case demonstrated how an adolescent girl identified with the mothering role of the playroom personnel.

The case of Mrs. Smith shows how a basically healthy parent, temporarily overwhelmed by crisis, can identify with and be taught effective mothering by a nurse:

Mrs. Smith was rooming in with her only child, a month old son having a hernia repaired. The nurse noted the mother was very tense in feeding the child and very fearful in handling him. The fear seemed to be related to lack of knowledge about the child's physical illness and the fact that Mrs. Smith was a new mother. The nurse explained the child's illness, respected the natural anxieties of motherhood, and provided education and encouragement. Within a few days, Mrs. Smith was more relaxed during feeding.

Because of the many pressures of a busy hospital, nurses and doctors frequently overlook opportunities to teach constructive patterns of child care and to allay parental anxieties. Albert Solnit¹² has discussed the importance, in the living-in situation, of having the staff help to deal with the crisis of hospitalization, so that it can become a growth experience to both mother and child.

Identification with staff can also broaden a child's vision of vocational choice.

For late adolescents a special value of the hospital

the chance to observe and investigate diversified
iations which may help them make a career choice.
child whose hospital experience was unpleasant
d terrifying may have been a potential doctor or
rse now lost to the profession (unless the child
entifies with the doctor as one who hurts in-
ad of heals, an undesirable trait in the "caring
ofessions").

Some children, especially older ones who have had
constructive hospital experience, express wishes to
ome physicians, nurses, technicians, and so forth.
ften these wishes are just passing fancies, but sometimes
they result in actual vocational choices.

A hospital has many special educational resources
d is a unique schoolroom.² Schoolwork should be
ntinued whenever possible for children hospitalized
ore than a few days. The hospital has many op-
rtunities for children to learn about the physical
d biological sciences, such as in diagnostic and re-
arch laboratories. The use of the hospital in this
ay might be considered for older children who face
ng-term hospitalization. Plank² gives an excellent
ample of a 16-month tutoring program for a 13-
ar-old boy in the biological and physical sciences.
his program stimulated the child and counteracted
e isolation and depression brought on by a long
spitalization, much of it in a respirator.

emotional Education in the Hospital

One essential aspect of a constructive hospital experience is to create a balanced emotional climate in which it is possible to learn by asking questions. Too often a child's questions about his illness, body, medical procedures, and the like are not answered. Hospital staff members often fail to understand the importance to children, especially those of school age, of intellectual attempts to master anxiety. Frequently, not only is the child denied an opportunity to achieve this mastery, but also his anxieties and fears about what is happening to him are increased by staff failure to recognize his natural curiosity.

The hospital can allay the child's anxieties about body processes, fluids, organs, and illness. Physical illness frequently exacerbates body concerns and pre-occupations, especially those related to fantasized punishment for bad behavior. The hospital is uniquely qualified to educate the child about his body and illness and can sometimes help alleviate guilt and anxiety. An alert nurse performed this function in the following case:

A 12-year-old girl was admitted for fainting spells, dizziness, vomiting, and mood swings of 1 week's duration. Physi-



The young woman feeding this sick child is one of several non-medically-trained child care workers hired by the Boston Floating Hospital to "mother" its young patients.

cal findings were negative. It was discovered that menarche had begun just 1 week prior to admission. The child showed considerable anxiety and guilt over this unexpected and unexplained occurrence. A nurse, with whom the girl felt comfortable, took the opportunity to discuss sexual maturation and answered her many questions. A noticeable improvement in the girl's symptoms occurred.

When staff members take the time to listen to hospitalized children, they are often amazed at the torrent of questions. Many questions, of course, relate to the child's illness, his body, and what is happening to him. However, except for children so critically ill that their entire attention is focused on themselves, ill children are curious about the entire hospital world, both human and physical. They want to know what a germ is, why nurses wear different hats, why Johnny has his head bandaged, what an X-ray or brain wave is, why pain hurts, why Billy died (and are they sick like he was), when their parents are coming to visit, when they can go home, why the nurse has to take blood from their finger, and on and on. Talking with the child can calm specific fears and contribute to his long-range education and development. Many families have difficulty allowing children to ask questions about anxiety-provoking areas. Some parents are often greatly relieved when a responsible agency helps them deal with subjects like illness, death, and sex that they have been unable to face with their children.

For example, a child's questions about what is wrong with some other patient provides an oppor-

tunity to help him develop empathy for persons with special handicaps—mental retardation, neurological impairment, loss of limbs, blindness, other bodily disfigurements, and emotional illness. In a constructive emotional climate, every attempt is made to answer such questions at the appropriate time in a manner consistent with the child's understanding.

Billy, 12 years old, was admitted for seizures, severe behavior problems, and learning difficulties at school. His parents, the school, and a child guidance clinic were unable to deal effectively with his violent temper tantrums. His peer relationships were poor, for he frequently assaulted children. While hospitalized, he developed an affection for a 6-year-old, grossly overweight boy who also had a behavior problem himself—whining, crying, screaming for food and his mother, and throwing violent tantrums whenever a doctor or nurse came near him. Taking a blood sample on this 6-year-old was a major procedure, but Billy had the amazing ability to get him to behave. With Billy at his side, the child would hold out his hand for the technician to take blood. Soon the staff was using Billy to accompany the boy to X-ray, blood labs, examining rooms, all done without a whimper from the boy. "There's nothing wrong with him," Billy said, "except that he's scared of doctors. I know just how he feels."

When the hospital encouraged this relationship, Billy developed techniques for relating positively, revealed empathy, and gained some insight into the relationship between fear and aggressive behavior.

Hospitalized children frequently soil, wet, suck their thumbs, and regress in other ways, and are extremely anxious about their need to do these things. One of the most constructive emotional experiences the hospital can offer is permission for, and acceptance of, the child and his regressive symptomatology. Regression, often a necessary part of illness, is difficult for staff or patient to accept. It is even more disturbing to a child because he almost always sees it as a threat to his autonomy and recent hard-fought struggles to grow up. The accepting climate created by adults around him can help the child accept himself. In this way it contributes to the child's total personality development and recuperative process.

A serious concern for the total welfare of the hospitalized child requires that we give more thought to the constructive role the hospital can play in a child's emotional growth. This is crucial because so few children completely escape a hospital experience. Previous work has focused on alleviating or neutralizing the potentially traumatic effects of hospitalization; however, it is not enough to discharge a child as physically healthy but emotionally unchanged. Hopefully, a child can leave the hospital also stronger emotionally. While a child psychiatry unit in the hospital may help to create a positive climate, hospitals without such units can still create a therapeutic atmosphere. This view may be an ambitious one but as a 6-year-old patient said: "The most important thing about this hospital is *ME*."

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³ Langford, William S.: *The child in the pediatric hospital: adaptation to illness and hospitalization*. *American Journal of Orthopsychiatry*, October 1961.

⁴ Jessner, Lucie; Kaplan, Samuel: *Observations on the emotional reactions of children to tonsilectomy and adenoidectomy*. In *Problems of infancy and childhood*. (Milton J. E. Senn, ed.) Josiah Macy, Jr. Foundation, New York. 1949.

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¹⁰ _____: *Practice of pediatrics—a play program for hospitalized children: the role of the playroom teacher*. *Pediatrics*, November 1962.

¹¹ Rose, John A.: *Sonis, Meyer: Separation in parent-child emotional crisis*. *American Journal of Psychiatry*, November 1959.

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... It is all very well for the man who is surfeited with all the choices of our lavish market place to wonder about the materialistic values of our affluent society. But the man who can't afford to buy even the cheapest meat, or pay his child's doctor's bills, or keep his youngster in high school also cannot afford the luxury of this kind of speculation. . . .

—Elizabeth Wickenden, Technical Consultant on Public Social Policy, National Social Welfare Assembly, to the annual meeting of the Community Health and Welfare Council, Cincinnati, April 1964.

*Thirty years of treating children who
suffer from seizures provide some
answers to the question . . .*

WHAT HOPE FOR THE CHILD WITH EPILEPSY?

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WHEN I BEGAN to treat epilepsy approximately 30 years ago, the number of patients whose seizures were controlled sufficiently to enable them to function normally was relatively small—probably less than 10 percent in our clinic, the Johns Hopkins Hospital Epilepsy Clinic. Twelve years later, in 1946, we found that 17.4 percent of a group of epileptic patients who had been followed in the clinic for at least 15 years had been seizure free for more than 5 years.¹

We are currently in the process of determining the incidence of seizure control in 15,104 epileptic patients who have been followed in the clinic during the past 30 years. Although the study has not yet been finished, the figures on hand thus far indicate that complete seizure control was obtained in approximately 60 percent of the patients; in another 25 percent, the seizures were reduced in frequency enough to make it possible for the patient to live a fairly normal life. In the remaining 15 percent of the patients, the seizures resisted all forms of anticonvulsant therapy.

In addition to the marked increase over the years in the number of patients whose seizures have been satisfactorily controlled, we have also observed a gradual improvement in the general well-being of patients with epilepsy, particularly a marked dimin-

ition in the number and magnitude of emotional difficulties.

The improvement in the overall outlook for persons with epilepsy may be attributed to such factors as: diagnostic advances, therapeutic advances, improvement and expansion of services, and modification of restrictive legislation.

Diagnostic Advances

Electroencephalography—a method for recording the electric activity of the brain, introduced in this country in the late thirties—has played a major part in bringing about a better outlook for the epileptic patient. It has done this in four ways:

1. It supplies information of significant diagnostic value to the physician in instances in which a definite diagnosis cannot be made on clinical grounds—for example, in cases in which the clinical history of a seizure is vague or questionable, or in cases of patients with nonconvulsive symptoms such as recurrent dizzy spells or recurrent fainting spells. Prior to the advent of electroencephalography, these nonconvulsive manifestations were frequently classified as functional disturbances if no organic basis for the symptoms could be found.

2. It is exceedingly valuable in classifying the

various types of epileptic seizures. Ability to distinguish between the various types of epileptic seizures is important, because drugs which are capable of controlling one type of seizure may be ineffective against other types, or may, in fact, increase their frequency. For example, Dilantin, which increases the number of petit mal spells in some patients, is one of the most effective agents for the control of psychomotor spells. And Tridione, which is very effective in the control of petit mal spells, is ineffective in treating psychomotor seizures.

The inexperienced physician may have considerable difficulty in clinically differentiating a petit mal spell from a brief psychomotor seizure. However, the electroencephalogram (EEG) almost always provides information which assists the physician in differentiating these two types of seizures. The EEG of petit mal epilepsy shows abnormalities consisting of the classic diffuse bilaterally synchronous spike and wave dysrhythmia, whereas the EEG of psychomotor (or temporal lobe) epilepsy usually reveals electrical aberrations, generally spikes, which are limited to the temporal areas of the brain.

3. Electroencephalography is particularly important to the neurosurgeon, since it frequently provides information which assists him in localizing epileptogenic foci.

4. In the research laboratory, the electroencephalograph has probably done more to clarify the problems of seizure disorders than any other discovery of the past 25 years.

Therapeutic Advances

Drugs and Therapeutic Regimens. Prior to 1939, the only antiepileptic drugs of any value were bromides and phenobarbital. However, in the past 25 years a number of new anticonvulsant drugs have been introduced and successfully employed against seizures. They include Dilantin (1939), Tridione (1944), Mysoline (1952), and Zarontin (1961).

Improved technique in the administration of the ketogenic diet regimen (a high fat, low carbohydrate diet) has also contributed to the better outlook for the child with epilepsy. This regimen, which produces an abnormal number of ketones in the body, is most effective in the control of epileptic seizures in young children.²

Although the surgical treatment of epilepsy cannot today be recommended for more than a fraction of the epileptic population, good results have been obtained in carefully selected cases.³ However, in-

creased interest and improvement in surgical techniques indicate that more frequent good results from surgery will eventually be obtained.

Early Treatment. In the past, physicians did not usually make a diagnosis of epilepsy until the patient had experienced many seizures. Today, however, most physicians seriously consider such a diagnosis after the patient's first convulsion of undetermined origin. In our clinic, we immediately prescribe daily anticonvulsant medication to all patients who have had one epileptic seizure.⁴ We have found that the degree of success in the control of seizures bears a direct relationship to the duration of the epilepsy: the longer the patient has been having seizures, the less likely it is that a satisfactory result will be obtained. Early measures to prevent a recurrence of seizures are important, not only for future seizure control but also to prevent the injuries, brain damage, and emotional disorders which sometimes result from seizures.

Prolonged Therapy. Years ago, it was the general policy of our clinic to discontinue medication about a year after the patient's last seizure. Later, the duration of therapy was increased to continue for 2, 3, and then 4 years after the last seizure. This was followed by a considerable reduction in the number of patients who had seizure recurrence. Today, we continue medication for at least 4 years after the patient has been free of seizures and, in some instances, particularly with adults, for the rest of the patient's life. The longer anticonvulsant therapy is continued, the less likely a patient is to have recurrence of seizures after therapy ends.

Gradual Withdrawal of Medication. Some physicians—myself included—used to withdraw effective antiepileptic medication either abruptly or over a very short period. However, observations have shown the importance of gradualness in withdrawing antiepileptic medication if freedom from seizures is to be maintained. A sudden withdrawal is a frequent cause of seizure recurrence or of status epilepticus, a state of continuous convulsions.

The length of the withdrawal period is governed by the amount and type of medication the patient had been taking—usually 1 to 2 years in patients who have been taking an average amount of anticonvulsant medication. A gradual withdrawal is particularly important in cases of major motor (grand mal) seizures.

Treating the Whole Patient. About 30 years ago

treatment of epileptic patients in most clinics, including our own, consisted almost exclusively of giving the patient some type of medication and telling him to return later if his seizures were not helped. As time went on, clinicians began to realize that medical attention should be directed not only to the seizures *per se*, but to the "whole individual," since the epileptic patient frequently has many other problems related to his seizure disorder. We soon learned that when we took the time to sit down with the patient or his parents, or both, and gave them the opportunity to discuss their problems—emotional, medical, and socioeconomic—our overall results became progressively better. Now we believe that the consideration of such problems as how to cope with epilepsy, how to get schooling, and what the future holds is just as important as the administration of antiepileptic medication. In dealing with these problems, the physician now works closely with members of other professions, such as social workers, psychologists, and public health nurses.

Approved Services

Specialized Epilepsy Clinics. When I began working with epileptic patients, few clinics in this country offered specialized care to children with epilepsy; most of them were treated in the general dispensaries. Also, relatively few physicians showed special interest in epilepsy. In fact, many patients were receiving their treatment from mail-order drug houses. One of the most significant advances made in behalf of epileptic children has been the development of epilepsy programs as a part of federally aided State services for crippled children. Twelve times as many children received care for epilepsy through these programs in 1963 as in 1950, according to reports made to the Children's Bureau. In 1963, 33 States accepted children with epilepsy for service, as against only 17 States in 1950. The service varies in comprehensiveness from State to State—ranging from diagnostic workup of an occasional child to a multidisciplinary service which provides diagnosis, treatment, and followup care for children in all parts of the State.

In my own State of Maryland, all children with seizures can receive expert diagnostic evaluation and regular followup care through the State epilepsy program, which began operation in 1950 as part of the State crippled children's services. Routine followup is regarded as especially important, since the patient needs to be seen regularly to have the dosage of his medication adjusted, to be examined for drug

reactions, and to have an opportunity to discuss his special problems.

Prior to the institution of the Maryland epilepsy program, specialized medical care was not readily available to many children afflicted with epilepsy, particularly those residing in rural areas. Now, however, under the Maryland epilepsy program, epileptologists from the medical centers conduct clinics at regular intervals in the various rural counties of the State. The program also offers consultation services to the local practitioner in both rural and urban areas. It has been responsible not only for improvement of medical care for all epileptic children in the State but also for a better understanding of epilepsy by the public, thereby helping to eliminate some of the many unwarranted stigmas associated with epilepsy.

Increase in Physicians Treating Epilepsy. Obviously, an individual with any medical disorder should consult his personal physician about "what to do and what not to do." While for many years the medical profession considered epilepsy to be entirely a problem for the psychiatrist or the neurologist, in recent years more and more general practitioners and pediatricians have become interested in, and have learned more about, the disorder. This is progress in the right direction. Since epilepsy is a disorder of childhood—approximately 90 percent of patients experience their first seizure during childhood—the pediatrician or the general practitioner is usually the first physician to be consulted after the first seizure occurs. Therefore, the patient would be most likely to receive appropriate therapy at an early date if the pediatrician or family physician considered epilepsy to be within his competency.

I believe that most pediatricians and general physicians can adequately care for a child with epilepsy. Of course, in some instances they may desire to consult a neurologist or a physician who specializes in convulsive disorders to establish a diagnosis and to assist in the management of the more complicated cases.

Lay Organizations. In recent years, a number of lay organizations have been established which offer important services both to the epileptic patient and, in many instances, to his physician. These services include referral to appropriate resources, personal counseling and information, research, professional consultation, professional and public education, development of educational and job opportunities for patients, and social action to modify legislation

which discriminates unnecessarily against persons having epilepsy. By associating with one of these organizations, the epileptic patient not only can gain much personal help, but also can contribute to a better general understanding of epilepsy. At the same time, he is likely to gain emotional support from the knowledge that national attention is concentrated on his type of disorder and its associated problems.

At this writing four national voluntary lay organizations concerned with epilepsy are operating in the United States: the American Epilepsy Federation, Quincy, Mass.; the Epilepsy Foundation, Washington, D.C.; the National Epilepsy League, Chicago, Ill.; and the United Epilepsy Association, New York, N.Y. Each organization has local chapters in various communities throughout the country. A movement is now in progress to amalgamate the four into one national organization to be called the Epilepsy Association of America. This would eliminate much unnecessary duplication of effort and resultant confusion.

Modification of Legislation

Within recent years, a number of States have repealed or modified laws and policies which denied to persons with epilepsy normal human rights such as marriage, having children, going to school, and choosing their occupation. Such restrictions were put on the statute books or in official regulations at a time when heredity was thought to be the major causal factor in epilepsy and when drugs for controlling seizures were not available. However, in spite of the fact that today the genetic factor in epilepsy is thought to be small,⁵ four States still have laws prohibiting the marriage of persons with this disorder. More have laws requiring their sterilization, but these are only rarely enforced. Other official policies—statewide or local—restrict the employment and educational opportunities of epileptic patients even after their seizures have been controlled.

Such restrictions should be abolished or modified to allow for consideration of the condition of the individual. Their sweeping nature serves no real social purpose and adds considerably to the emotional difficulties of persons with epilepsy by preventing them from living normal lives and by supporting the stigma attached to epilepsy in many people's minds. Most of the emotional disturbances observed in patients with this disorder are not manifestations of the disorder itself, but are results of a hostile society which has discriminated against them since the dawn of recorded history.

Happily, the attitude, "once an epileptic, always an epileptic," has been abandoned by most motor vehicle commissioners and their medical advisory boards today, in most States, a person whose epileptic seizures are controlled is allowed to operate a motor vehicle. This not only has a favorable psychological effect on the individual, but often helps him advance his economic status because of the many types of employment it opens up.

Goals Ahead

In spite of the advances in the management of epilepsy in the past few decades, many goals have yet to be attained:

1. A major goal is to *determine the cause* of the disorder. True, the advent of electroencephalography has greatly assisted in classifying specific types of seizures, and the ingenious investigations of medical researchers, such as Ajmone-Marsan, M. Baldwin Gastant, the Gibbses, Lennox, Penfield, Jasper, and Walker, have produced significant information regarding the presumptive site of seizure origin in many patients. But the specific cause of epilepsy remains undetermined.

Some investigators assert that brain damage is the cause. Certainly brain damage plays a part in some cases. However, I do not believe that brain damage *per se* is the sole cause of epilepsy.

True, acute brain damage, either from trauma or infection, is frequently accompanied by a seizure. Residual brain damage, however, cannot be the sole cause of recurrent epileptic seizures for two reasons: (1) all individuals who sustain brain damage of a similar nature do not develop epilepsy—for example, only 25 to 30 percent of patients with cerebral palsy have epileptic seizures; and (2) if permanent brain damage were the only cause of recurring epileptic seizures, the afflicted individual would be in a constant state of seizures, since the brain damage is present at all times.

However, since recurrent seizures do develop very frequently in individuals after they have sustained brain damage, this may be regarded as a predisposing factor in epilepsy. It is reasonable to assume that a given individual might never have developed epilepsy had he not sustained brain damage, although one can never be completely certain of this. In some manner, it seems, brain damage lowers the individual's convulsive threshold.

Another hypothesis as to the cause of epileptic seizures focuses on disturbances which produce defects in the physiological, metabolic, enzymatic, or

chemical systems of the brain. No significant evidence has been presented, to my knowledge, which definitely proves that any one, or a combination, of these cerebral defects is unquestionably the cause of epilepsy.

Some physicians classify all persons with epilepsy, regardless of their mental status or the absence of neurological deficits, as brain-damaged individuals merely on the basis of the occurrence of epileptic seizures. True, some persons with epilepsy have brain damage, and some patients with epilepsy are mentally retarded. However, the vast majority of patients with epilepsy have at least normal intelligence and do not manifest any neurological evidence of damage to the brain. Moreover, post-mortem examinations and gross anatomical and microscopic studies performed on the bodies of many patients who had epilepsy have not revealed evidence of damaged brain tissue.

I believe that to classify a person who has recurrent epileptic seizures as "brain damaged" or "brain injured" merely on the basis of the seizures themselves is not medically sound. If continued, the close association of brain damage with mental retardation in the minds of the laity can push epilepsy "back into the closet" from which it has just started to emerge, seems more appropriate to classify an individual with epilepsy as one suffering from "transient states of cerebral dysfunction of unknown cause."

2. Statewide projects similar to the Maryland epilepsy program are needed in *all* States. Since epilepsy is one of the most common of the disorders which have a tendency to be chronic, systematic regular care should be available to every epileptic child as it is for children with some other types of chronic disorders such as cerebral palsy.

3. More research is needed. The vast majority of patients with major motor (grand mal) seizures can satisfactorily control their seizures with the antiepileptic agents now available. The same is true to a lesser degree of patients with petit mal epilepsy. However, the current therapeutic armamentarium is not very effective for the treatment of the other two common types of epilepsy: psychomotor (or temporal lobe) and minor motor (infantile spasms, hypsarrhythmia). Thus there is much need for continued research to find new therapeutic agents for the control of these two types of seizures. Significant investigations of new anticonvulsants are now being conducted by several large pharmaceutical manufacturers.

4. There is great need for *improvement in society's attitude* toward the disorder of epilepsy. Many persons are still imbued with the many misconceptions about epilepsy which were so prevalent in the past. Because of this, epilepsy still remains one of the "hush-hush" diseases. The activities of the lay epilepsy organizations constitute one of the most effective means of dispelling the stigmas associated with the disorder. They should be even more effective when these organizations combine.

5. The major difficulty encountered by persons with epilepsy is *securing employment*. This is due mostly to the fact that many employers believe that all persons so afflicted are less proficient and more prone to accidents than normal workers. This notion has no medical or statistical basis. On the basis of my observations of thousands of persons with epilepsy, I would guess that, on the contrary, the accident rate of the selectively placed epileptic worker is less than that of the non-epileptic worker, and that his work efficiency is at least equal and, in many instances, superior to that of the normal person.

Many employers I have talked to seem to think that the workmen's compensation law prohibits the employment of individuals with epilepsy. Actually, *no* provisions in the workmen's compensation law, or rates set under it, penalize an employer for hiring persons with any type of handicap. Of course, some persons with epilepsy are inappropriate candidates for employment. This does not make it necessary to apply the designation "unacceptable" to the entire epileptic population.

There are at least 2 million persons with epilepsy in the United States. In this day when the importance of "equal opportunity" for all is stressed, they should not still be classified as "second-rate citizens." They should be assessed in the same manner as any other individuals; that is, according to their physical and mental ability to function in society.

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² Livingston, S.: Diagnosis and treatment of convulsive disorders in children. Charles C Thomas, Springfield, Ill. 1954.

³ ———: Living with epileptic seizures. Charles C Thomas, Springfield, Ill. 1963.

⁴ ———: Management of the child with one epileptic seizure. *Journal of the American Medical Association*, Sept. 10, 1960.

⁵ Eisner, V.; Pauli, L. L.; Livingston, S.: Hereditary aspects of epilepsy. *Bulletin of the Johns Hopkins Hospital*, Vol. 105, 1959.

WHY SO FEW NEGRO ADOPTIONS?

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THE LACK of adoptive homes for Negro children in need of placement is a problem familiar and painful to persons concerned with the welfare of children. About 70 percent of the white children born out of wedlock are adopted, as compared with less than 10 percent of the nonwhite children.¹

The painful aspect of these figures lies in evidence about the fate of many children born out of wedlock who are not adopted. No doubt a considerable number are absorbed into the maternal family without serious adverse effects. Some, however, remain indefinitely in institutional or foster family care; and frequent replacements of such children are not uncommon.² Some children born out of wedlock remain with mothers who are unable or unwilling to care for them adequately, and who may not have access to the services they need to help them become more effective parents. For example, a mother may need to work to support her child but be unable to provide him with adequate supervision while she is out of the home.³ Or keeping the child at home may interfere with a young mother's obtaining needed schooling for herself, and so the child becomes caught, with her, in the cycle of poverty and dependency associated with poor education and lack of vocational training.

Thus there are solid grounds for concern about the fact that there are many more Negro children in need of adoptive homes than there are couples wanting to adopt them.

A review by the Children's Bureau of available reports on research and demonstrations relating to births out of wedlock has brought out a number of findings and assumptions concerning the need for more Negro adoptive homes and the effectiveness of efforts to stimulate Negro adoptions.⁴⁻¹⁴

Some Assumptions

One assumption, widely current some years ago, is less widespread today: that Negro unmarried mothers seldom, if ever, wish to place their children in adoption. While many Negro unmarried mothers obviously do wish to keep their children, the large number of Negro infants abandoned in the hospitals where they were born is tangible evidence that many do not. In line with such evidence, the executive director of a maternity home for Negro unmarried mothers said, in an informal interview, that 40 percent of the residents ask to relinquish their babies and that this would probably be closer to 60 or 70 percent if there were any likelihood of the babies being accepted by placement agencies.

Reports from other sources also indicate that desire to relinquish children born out of wedlock far outweighs desire to adopt them. A participant in a recruitment drive for Negro adoptive homes, launched by several voluntary agencies, commented that the first response to the project was not from prospective adoptive parents, but from unmarried mothers wanting to place their babies. This social worker made

int that is supported by experience as well as by reading between the lines of some research reports: that if unmarried mothers do not believe they will be able to place their children, they do not mention option placement when they are asked whether they need or want social services.

Another assumption is still prevalent: that Negro couples are less ready than white couples to adopt children, chiefly because Negroes do not know about the availability of adoption services and of babies to be adopted. A number of projects have attempted to demonstrate the effectiveness of a coordinated communitywide effort to bring to the attention of the appropriate segments of the Negro population the opportunities that exist for the adoption of Negro children. These projects have been based on the premise that the apparent apathy of Negro couples toward the idea of adopting is due primarily to ignorance about the availability of Negro children, misconceptions about application procedures, fear of rejection by prying or prejudiced social agencies, red tape, and the like. Therefore, their major efforts have been directed toward correcting misinformation, lack of information, and stimulating the interest believed to be latent in the community.

Typically, such projects have used various forms of public education, including spot radio or television announcements, newspaper publicity, speakers' bureaus, bus placards, and informal discussions organized through church, professional, and labor groups in Negro communities. The active participation of Negro community leaders has usually been secured, direct mailings to members of organizations, and pamphlets and brochures placed in offices of social agencies, doctors' offices, beauty parlors, and barber shops have also been used.

One adoption agency held meetings with Negro couples who had already adopted children, to get suggestions about methods of recruitment based on their experiences. In two projects, mailings were sent to Negro families who were giving foster care to children. In another, meetings were held for Negro adoptive couples and prospective applicants, with the adoptive parents answering the applicants' questions—the theory being that "the best advertisement is a satisfied customer."

In their conclusions, reports of such projects tend to find merit in an organized, consistent, and cooperative community educational program to stimulate interest in the adoption of Negro children. However, some reports are not wholly enthusiastic about the results actually obtained. Moreover, analysis of

the figures reported indicates that the numerical increases in applications are modest and suggests that the proportions of dropouts and rejections among applicants are likely to increase during such a drive.

An exceptionally systematic and carefully reported study by Fanshel,⁴ based on applications over a 5-year period (1951-55), comments on "the relatively small number of those couples who had come [to the agency] on the basis of newspaper or radio-television [announcements] who went on to adopt a child." Fanshel sees the chief beneficial results of "broad public relations efforts" as indirect and long term, rather than immediate and direct. Like other investigators, he notes improvements in agency morale and "commitment," in interagency communication, and in mutual understanding between agencies and individual professional people, with consequent improvement in referral practices. He reports also that some applicants who withdrew after an initial contact returned later and completed an adoption.

Since most reports are sketchy and since criteria vary from one report to another (and not all give actual figures), there is still room for further inquiry into the sustained effectiveness of such projects and whether it is substantial enough to offset the financial cost, professional time, and community energy they consume. Careful review of the available reports

A young couple with their newly adopted baby. The accompanying article raises some points to question the assumption that Negro couples in a position to adopt are less ready to do so than white couples in similar circumstances.



seems to support the comment of Deasy and Quinn: "Social agencies on both the local and national levels have been trying for years to increase the numbers of Negro children who are legally adopted. But the success of such programs seems to have fallen far short of expectations and aspirations."⁵

Reasons for Not Adopting

After a review of relevant studies and demonstrations, Deasy and Quinn concluded that the apparently limited success of such efforts might arise from error in the assumptions on which they are based. Accordingly, they launched a systematic investigation designed to test those assumptions by obtaining answers to the question, "Why don't Negroes adopt children?"⁶

In this investigation interviews were held with 484 Negroes living in two communities—Baltimore (161 respondents) and Washington, D.C. (323 respondents). The respondents were people who, by the usual social agency standards, would be eligible as adoptive parents: partners in intact marriages, between the ages of 25 and 50, either childless (52 percent) or with a child over 5 years of age, and living in neighborhoods that were predominantly stable economically. They were longtime residents of the cities they lived in, more than 60 percent owned their own homes, 60 percent had held their present jobs for more than 10 years. In short, these people had the outer manifestations of stability and security.

The respondents were found to have an understanding, or at least a knowledge, of adoptions and why they become necessary. The majority (89 percent) knew about the adoption work of social agencies, and, although some were articulate in their criticism, they tended to regard these agencies as the best source of adoptive babies; 88 percent knew someone who had adopted a child and, although not interested in adopting a child themselves, appeared to approve the idea of adoption.

The respondents ascribed the shortage of Negro adoption homes to agency practices: "snooping," red tape, overly stringent requirements, and long waiting periods—even though the great majority of those who knew about adoption agencies said they were doing a good job. Most of them said that their main concern about a child would be in regard to his physical health and mental history rather than his birth status, parents' social position, or mother's age at the time of his birth.

The investigators commented:

... it is not . . . for lack of information about adoption . . .

Our respondents think of agencies as a prime source of adoptive children and express no great fear of involvement with them. Yet there seems to be a basic lack of motivation to adopt . . . the reasons for this lack of motivation must lie in the values to which successful urban Negroes subscribe. Surely many of the childless respondents we saw were childless by choice. If one chooses not to have a child by the biological process, why adopt one through an agency? . . . Parenthood involves risk . . .

. . . We know too well that to attain that state of mind that makes it possible to contemplate the future with any measure of equanimity is difficult for everyone these days—and perhaps more so for Negroes . . . As the future becomes more trustworthy for them, let us hope that more Negroes can trust and can look to a future that includes children—either born to them or taken as their own.⁵

The same investigators later undertook a similar study in which white couples in the same cities were asked the same questions. It will be interesting to compare the results.

Are Negroes Less Interested?

None of the studies or demonstrations reviewed raised any question about the assumption that there is, as Deasy and Quinn put it, a "crashing lack of interest among Negroes in the adoption of children." Nevertheless, a question should be raised: Is there really less interest in adoption among Negroes than among whites, or does the scarcity of adoptive applicants merely reflect the relatively larger number of babies available for placement and the relatively smaller number of couples in a position to adopt?

The number of nonwhite children born out of wedlock each year is half again as large as the number of white children born out of wedlock. Yet there are many times more potential adoptive parents among the white population than among the nonwhite. To begin with, the white population is about 10 times as large as the nonwhite. In addition, the white population has, on the whole, far more income annually and far more economic security than the nonwhite. In 1961, for example, nearly half the nonwhite families in the United States had incomes below \$3,000 and nearly one-fourth fell below \$1,500—as compared with not quite one-fifth and about one-fourteenth of the white families.

Further analysis of Bureau of the Census figures on the characteristics of the white and nonwhite population of the United States, and of Children's Bureau reports on adoption, reinforces doubts about the widespread assumption that Negro couples are, on the whole, more reluctant than white couples to adopt children.

For this analysis we are indebted to Hannal

dams of the Division of Research, Children's Bureau. Miss Adams was hampered in her computations by lack of data from a number of States, and therefore conclusions from them must be qualified accordingly. Even so qualified, however, they call for a new look at an assumption that has been remarkably free of challenge.

She found that for the country as a whole, in 1961—if one considers only husband-wife families with heads under 45 years old—the ratio of nonrelative adoptions was 3 per 1,000 couples for all races combined and also for the white population. For negro husband-wife families of the same age, it was 7, only a little lower.

When income was considered as well as family composition in the analysis, a more striking challenge to the assumption emerged. It seems reasonable to suppose that the great majority of legal adoptions occur in families with incomes over \$3,000 a year. If this is so, then families with less than this amount of income ought to be excluded from the base population used in figuring the adoption ratio.

When this was done, the adoption ratio for the United States in 1961, for all races combined, rose from 3 children adopted by nonrelatives per 1,000 husband-wife families with heads under 45 to 3.5 per 1,000 such families. For white families, the ratio rose only from 3 to 3.4. But for nonwhite families it rose to 4.9.

Apparently, either those nonwhite families having higher incomes were *more* likely than white families to adopt children not related to them, or a significant number of nonwhite families with incomes under \$3,000 adopted children—or possibly both.

Thus it appears that the lower proportion of two-parent families found among Negroes, and the notoriously low-income levels so prevalent in this minority group, fully account for the dearth of negro adoptive applicants, without any need to assume different attitudes toward adoption. (It should be remembered also that we are discussing here only legal adoptions, leaving aside informal arrangements of child care which are not legalized.)

The figures are not offered as conclusive. However, even when due allowance is made for the fact that they are based on estimates, they strongly suggest that group differences in the availability of adoption as a resource for child care relate to income and family composition, rather than to differences in attitudes toward adopting. In other words, review of the evidence indicates that coordinated campaigns of public education have been disappointing because

they have been based on false premises. Contrary to the frequent assumption, Negroes are *not* less interested in adopting than are whites among those in a position to adopt, nor are they less informed about adoption. Community demonstrations have been expected to cure a condition that apparently did not exist.

Educational campaigns about adoption directed at Negro populations can probably help to some extent, but they cannot be expected to correct the main problems, since they are not directed to the main problems. The test of their effectiveness will be, not whether they can raise the Negro adoption rate as high as the rate among white couples, but whether they can increase still further the amount by which it already exceeds the white rate among couples who are in a position to adopt a child.

Other Possible Approaches

The evidence reviewed does not deny the possibility that adoption rates among Negroes could be increased. It shows merely that the main problem in placing Negro children does not stem from ignorance or apathy in the Negro population, and that publicity efforts alone are not likely to solve the problem.

It becomes necessary, therefore, to look for other means of solution. The evidence suggests that these should be designed, not for bringing about change in the potential adoptive parents, but rather for bringing about change in the circumstances that, directly or indirectly, encourage or discourage adoption. We cannot here spell out what these changes should be. We can, however, indicate three possible approaches to coping with the scarcity of adoptive homes for Negro children:

1. *To modify some adoption policies and practices* which are criticized in a number of study reports. In the criticisms it is not always possible to separate prevailing misconceptions from actual fact. However, both Fanshel's study⁴ and the one conducted by MARCH⁶ (Minority Adoption Recruitment of Children's Homes) report high withdrawal rates among applicants for children and document the points at which agency practices (as of the fifties when these studies were made) appeared to alienate prospective adoptive parents. It should be added that a good many adoption agencies—including some of those whose placements were studied—have shown outstanding readiness to look critically at their own procedures and have already introduced modifications that might be expected to reduce the number of ap-

plicants who voluntarily withdraw.^{7,8} Other modifications introduced by some agencies might more accurately be called innovations—for example, subsidizing the child in an adoptive home which meets all the requirements except financial ability.

2. To expand resources other than adoption placement for children for whom adoptive homes are lacking—for example, increasing payments for foster care and developing good group care arrangements.

3. To modify the conditions that cause the problem—a more potent but also a more difficult method than the other two. The large numbers of Negro babies in need of placement reflect the prevalence of lower incomes among Negroes and the high incidence of broken homes and births out of wedlock that are associated with extremely low incomes among both Negroes and whites. The prevalence of these conditions among Negroes reflects, in turn, the low status—both social and economic—of a minority group in an affluent society. Efforts are afoot to improve that status. Success in these efforts could help to reduce the amount of poverty, the proportion of broken homes, and the rate of out-of-wedlock births. In the process it could also help to reduce the discrepancy between the number of babies who need homes and the number of homes ready to receive them.

It is not necessary to wait for major changes in socioeconomic conditions before attempting to increase the number of Negro adoptive homes. On the contrary, every feasible step should be taken. However, it is probably unrealistic to expect a major increase in Negro adoption rates until major changes in socioeconomic conditions are well under way.

⁷ Adams, Hannah, M.; Gallagher, Ursula M.: Some facts and observations about illegitimacy. *Children*, March-April 1963.

⁸ Maas, Henry S.; Engler, Richard E.: Children in need of parents. Columbia University Press, New York, 1959.

⁹ Herzog, Elizabeth: Children of working mothers. U.S. Department of Health, Education, and Welfare, Social Security Administration, Children's Bureau. CB Publication No. 382. 1960.

¹⁰ Fanshel, David: A study in Negro adoption. Child Welfare League of America, New York. 1957.

¹¹ Deasy, Leila C.; Quinn, Olive W.: The urban Negro and adoption of children. *Child Welfare*, November 1962.

¹² Minority Adoption Recruitment of Children's Homes (MARCH): Adoptive placement of minority group children in the San Francisco Bay Area. San Francisco, Calif. 1959.

¹³ Allen, Alexander J.: A commentary on a study of Negro adoptions. In *A study in Negro adoption* (David Fanshel). Child Welfare League of America, New York. 1957.

¹⁴ Hawkins, Mildred: Negro adoptions—challenge accepted. *Child Welfare*, December 1960.

¹⁵ Buffalo and Erie County Community Welfare Council: Report and recommendations of the committee for Negro adoptions. (Mimeographed.) Buffalo, N.Y. May 10, 1961.

¹⁶ Dukette, Rita; Thompson, Thelma G.: Adoptive resources for Negro children—the use of community organization and social casework in recruitment and development. Child Welfare League of America, New York. August 1959.

¹⁷ Foote, Gwendolyn: Report: "homes for children" project—1958-1962. (Mimeographed.) Connecticut Child Welfare Association, New Haven. Sept. 14, 1962.

¹⁸ Perry, Martha: An experiment in recruitment of Negro adoptive parents. *Social Casework*, May 1958.

¹⁹ Philadelphia Health and Welfare Council, Children's Division: Report of committee on Negro adoptions. (Mimeographed.) Philadelphia July 7, 1960.

²⁰ Thompson, Gertrude J.: Final report: "homes for children" project ended Dec. 31, 1958. (Mimeographed.) Children's Services of Connecticut, Hartford. (Undated.)

The material in this article is drawn from a review of research and demonstrations concerning unmarried mothers and their children, undertaken by the Children's Bureau. The review covered only reports published before 1963 and available to the Children's Bureau. Another portion of the review now in press, is entitled, "Health Services for Unmarried Mothers."

Whether talking about delinquency rates or school programs for the culturally deprived or desegregation or fatherless families or urban renewal, one eventually comes to the economic facts of life.

"Youth Problems: Poverty and Social Action Programs," in *The First Five Years, 1958-1963*, Syracuse University Youth Development Center, Syracuse, N.Y., 1964.

THE CASEWORKER'S ROLE IN SMALL GROUP HOMES

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RESIDENTIAL treatment of emotionally disturbed children in community areas is still a comparatively new development in child placement. For some social caseworkers who but a short time ago carried a caseload primarily consisting of children in foster family homes, there is a striking change in working with children living in small group homes in the community. The Jewish Children's Bureau of Chicago has found this to be true in the care of emotionally disturbed children in small group homes. The purpose of these group homes is to give disturbed children who cannot stand the close relationships expected in a foster family some of the advantages of a family and community atmosphere in a therapeutically planned residence.

In foster family care, caseworkers are expected to relate and adapt themselves to the children, their parents and relatives, foster parents, and numerous auxiliary persons—teachers, doctors, and workers from other agencies. While all these people represent influences in the life of the child, only the foster parents are accountable to the agency, and even they are not totally subject to agency discipline. While the caseworker occasionally confers with the case consultant or the psychiatric consultant, his primary responsibility is to his immediate supervisor.

When caseworkers at the Jewish Children's Bureau began placing children in residential care, a major change in their role occurred. Caseworker and supervisor were no longer an isolated entity per-

mitting others an occasional peek at their work only when they deemed it appropriate. Now, both quantitatively and qualitatively, their intense relationships were within, not outside, the agency.

The agency's group homes consist of six residential apartment units, housed in two 3-story buildings in a middle-class residential area. Living in each apartment are six children and a married couple, called child-care counselors, who care for the children and manage the household. In addition to the apartment units, each building contains recreational space, workshop equipment, and an office; and one houses a special school staffed by a principal and several teachers. A unit administrator for each building supervises the child-care counselors and coordinates their work with the work of the various other staff members involved in the children's total treatment—teachers, recreational and psychiatric consultants, and casework therapists. However, the therapeutic efforts of the caseworkers, whose caseloads may also include children in foster family care, are supervised by the agency's casework supervisors.

Thus, in working with a child in one of the residential units, the caseworker must share the child and his therapy not only with his agency supervisor but also with the child-care counselors, the unit administrator, the psychiatric consultant, the principal and teachers of the special school, the agency's group workers, its director of professional services, and others. The caseworker must be prepared to accept

regular, consistent, and thorough evaluation of his work from all of these colleagues. Even the children become sophisticated about the program, and often, with either great glee or anxiety—depending upon the nature of his transference in therapy—a child will ask what the rest of the team thinks of the caseworker's handling of the therapy.

Shared Responsibility

While this situation has created innumerable problems, it has also created the seeds for their solution. The needs of the child remain paramount in the team's thinking. Working effectively together rests in each member's ability to interact with the other team members with forthrightness and with as little defensiveness as possible.

Norman Lourie has said that "the entire staff must be oriented in the direction of the child's treatment. They should be people who can control and regulate their own attitudes, feelings, and handling of children; who can accept casework and psychiatric concepts as they are translated for them into ideas of living; who must be able to work under casework direction as part of the team."¹

Experience has shown, however, that we may have to amend and modify these concepts. "Casework direction," while effective in a foster family setting in a small group home, is overlaid with and complicated by "unit administrator direction," "psychiatric consultant direction," and "overall agency direction." Caseworkers and child-care staff must also be aware of and work with their attitudes and feelings toward the total team. In foster family care, the caseworker has been called the "guide for the therapeutic process." Now the "guiding" must become a common responsibility, for each member of the team has his own special role to play.

The caseworker's primary function is to carry out direct therapy with the child. In examining his own relationship to the team, his problems may appear to be insurmountable. However, his very involvement with the highly complex network and the different levels of communication and authority begins to suggest a solution.

The child-care counselors are the agency's closest link to the child, since they live with the children. However, with the development of the residential treatment program, the caseworker has moved out of the confines of his office and into the child's living situation. This means that a pair of child-care counselors in charge of six children may have six caseworkers invading the sanctity of their home, and

that the caseworker cannot help but observe some of the counselors' day-to-day handling of the children.

Each casework therapist is concerned primarily with the child on his caseload. His interest in the other children in the unit is dependent on their effect on the life of his child. Therefore, his first impulse is to direct the staff to serve the best interests of his child. He comes up with many ingenious and original ideas that he feels will contribute immeasurably to the health and adjustment of this particular child. He cannot understand why his enthusiasm is not always shared by the child-care counselors. Instead, he may find himself accused of overidentifying with the child, usurping the authority of the child-care counselors, the unit administrator, the principal of the school, or even of the casework director. At first, he is shocked. He has the feeling that the child-care staff means only to frustrate him; at the same time, the child-care counselors are apt to feel that the worker has come into their home only to disrupt it.

Facts must be faced. We caseworkers do identify with the children in our caseloads. Nothing suits us better than the child's improvement. If we step on others' toes in the process, we excuse ourselves by saying that these were obstacles hindering us from serving the child's best interests. When we examine our motivations for entering and remaining in the field of child placement, we find that what has sustained us is this intense interest in "our" children and our need for them to grow and develop. We would not be effective if we did not react to any real or fancied injustice to the child.

But with time, patience, heated discussions, even some hurt feelings, we learn that the world of the apartment units does not revolve around the caseworker and his child. The isolation in which the caseworker and his supervisor operate in foster family care cannot be duplicated in residential care.

To understand and resolve the problems, communication between the various persons serving the child is vital. But how and for what purpose? We are still experimenting. Much has been written about the techniques of staff communication in residential treatment settings. But rigid formulations and rules do not always fit realities. The day-to-day job demands a flexibility on the part of each staff member that disregards neither the agency structure nor the inherent roles and rights of the other team members.

With respect to the psychological treatment of the child, direct communication between the child-care counselor and the caseworker is essential. This may

em only simple commonsense. However, such communication does not always occur.

Let me illustrate. The caseworker who has an really deprived child in his office may allow the child to consume two cola drinks, one package of candy, and two bags of popcorn, though suppertime is only half hour away. This may convince the child-care counselor that the caseworker is not interested in the child's achieving a balanced diet. Seeing her carefully prepared supper refused, the counselor may scold this with the supervisor, or even make her concern evident to the child.

Or, to take another example, a child-care counselor, eager to support a child's ego, may tell a visiting parent how well he has done in school. The caseworker may feel that the best interests of the child require a minimum of communication between parent and child-care counselor and may mention this to the unit administrator. Some caseworkers believe that in such situations all problems should be filtered through the unit administrator, who then becomes a two-way street for information, ideas, and complaints. I do not believe this is a sound policy. It tends to create antagonists rather than collaborators, only when the child-care counselor and the caseworker can communicate directly with each other, share ideas, and vent their grievances can they achieve healthy, nondefensive, and rewarding experience.

Rewards of Communication

This does not negate the role of the unit administrator. Rather than act as a buffer or as a filter of ideas, the unit administrator can help the therapist and child-care counselor delineate and then fuse their ideas into the most meaningful experience for the child concomitant with the most effective management of the unit.

If the therapist can work effectively with the unit administrator and child-care staff, he will receive many rewards:

1. He will develop a new awareness of the problems and functioning in the residential unit as a whole. He will find that a unit geared to the needs of all the children it contains will create an atmosphere and a living experience for his child nearer to the conditions children face in normal living situations. At the same time, the child-care counselor will find that he can tolerate deviations in a child's behavior if he understands why they must be allowed. For example, if told that allowing a particular child to swear may deviate his stuttering, the counselor may learn to

tolerate the swearing, particularly if he realizes that allowing one child to swear need not prevent the child care staff from prohibiting such language among children who are freer in acting out their aggressive feelings.

2. The therapist will develop a greater awareness of overall agency problems and needs. He will not fall into the trap of taking sides with a child who is denied an extra 10 cents for lunch or told that he may not bring a frog into the building. It does not help the child to feel that his therapist is either omnipotent or subject to the same overwhelming frustrating forces that he feels in himself.

3. The therapist will learn that he has a distinct and separate role. While each may try, neither the child-care counselor nor the therapist will be able to make up to the child completely for the true parental figures who could not meet his needs. An apartment unit with six unrelated children and surrogate parents hardly makes "a family" although it carries out certain family functions. Much less is the therapist a substitute for the child's family.

There are certain functions which a therapist should not usually assume, if he wishes the child to have a corrective experience. Without the consent of the counselor, he should not take the child shopping for clothes, pack his bags for a camping trip, or buy him a stick of bubble gum to take back to the apartment. In the social worker's need to "give" to deprived children, the casework therapist often finds himself not only in the role of an overprotective and indulgent parent but also in conflict with the external treatment goals in day-to-day living. When the caseworker makes it clear that he understands that the responsibility for the child's day-by-day care lies with the child-care counselor, the latter will gain a better understanding of the caseworker's role as therapist and of the unique meaning to the child of the therapist's office, where for an hour he may be permitted to regress, to indulge himself, and even to some degree to act out his aggressions.

Problems of Authority

Within the apartment units, the therapist finds that he becomes involved with the question of authority. Every member of the team is on a different authoritative level. Problems arise when there is an overlapping in the decision-making prerogative. At times, decisions must be made by individual team members immediately involved in a situation with

no opportunity to consult with other team members who ordinarily would have the major decision-making power.

Thus, occasionally, the therapist may have to perform a function more appropriate to a number of the resident staff; the child-care staff must make what is ostensibly a casework decision; or the unit administrator may have to make decisions more appropriately the responsibility of either the caseworker or the child-care counselor.

Rarely do such role exchanges do any irreparable damage. More often than not, the decision made is a correct one. Each such occurrence leads to intensive staff discussion of the child's total situation and of each member's separate role in meeting his needs, and finally to a greater understanding of the child's needs and his methods of handling his problems. This personal experience of staff communication in relation to day-to-day problems has proven more effective in creating real teamwork than numerous formal staff meetings called to delineate everyone's role. In such formal meetings the child is often ignored. However, such "integration meetings"—as they are called in our agency—do provide a valuable opportunity for staff members to air their feelings and to gain perspective on each others' part in achieving the agency's goals.

The Unifying Process

The agency's psychiatric consultants are actively and intensively involved in what goes on in the apartment units. They are not deskbound any more than the caseworker; nor is their knowledge of the child based only on the caseworker's written reports. As teachers, they are most effective when they see the total diagnostic and environmental picture.

All members of the team have certain vested interests beyond their total dedication to the mental health of the child. The unit administrator is interested in developing the fullest potential of the child-care counselors and will come to their support when necessary. The school principal is interested in his teachers and in helping them impart knowledge to the child. The casework therapist has a vested interest in the particular child with whom he is carrying on therapy. The vested interest of the psychiatric

consultant, on the other hand, is in every member of the team. His unique skill lies in blending the therapy with the day-to-day living situation and in helping in the total unifying process.

As I have already mentioned, the child is helped most effectively when team members have an opportunity to air their differences and feelings to each other. In the "integration meetings" which are led by the psychiatrist, suddenly all the various, diffuse, separate, and sometimes apparently unrelated feelings of the team jell and form a cohesive whole. A pattern emerges, and the direction for ongoing therapeutic goals takes shape.

In Summary

Thus, in his role as therapist in a residential unit, the caseworker must not only take on added responsibilities but he also must be ready to give up, or share, some of the decision-making powers that he has in working with children in foster family care.

The caseworker must remember that his communication with other staff members must always serve a definite purpose in the therapeutic goals for the child. It does this best when it is direct rather than when it is filtered through the unit administrator. But the unit administrator plays an important role in helping the caseworker and child-care counselors gain perspective on specific problems.

While caseworkers tend to over-identify with the child, they should acknowledge this tendency without apology. Experience shows that, with this intense interest in the child, the therapist's awareness of the milieu heightens and he becomes able to work more effectively with the child-care counselors.

Finally, while authoritative roles may be carefully defined, rigid application stultifies treatment. Experience has shown that, in less time than we have thought possible, a conscious effort by all team members to impart information and to respect and trust each other makes for less concern over *who* has made decisions that affect the child in his day-to-day living or in his therapy, than over the *effect* of these decisions on the child's emotional growth.

¹ Lourie, Norman V.: The children's institution: one step in casework treatment. *The Jewish Social Service Quarterly*, Winter 1954.

I. Strengthening Family Life

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CHILDREN deprived—physically, emotionally, educationally; children rejected; children battered and abused: these are the children who day are desperately in need of "extra" service. intensive help from the caseworker-homemaker team is essential if these children are to survive, and, beyond this, become adequate and understanding citizens of tomorrow.

Over 50 years ago, the White House Conference on the Care of Dependent Children stated: "Home life is the highest and finest product of civilization. It is the great molding force of mind and of character, and children should not be deprived of it, except for urgent and compelling reasons."¹

This is still the foundation of thinking in the child welfare field and it remains the broad base of all protective services to families in which children have not been receiving the care they need. Today, in "reaching out" and offering casework help which is not requested and which is sometimes not even understood, we work with parents with the aim first of helping them to understand their problems, and then of strengthening, supplementing, and supporting their efforts to improve conditions for themselves and their children to a point where they meet at least the minimum standards of the community—thus making it possible for the children to remain in their own homes.²

In St. Louis County (Mo.), the public child welfare caseload has been averaging some 1,300 children

per month—more than half of whom receive protective service in specialized caseloads containing from 28 to 33 families. Over the years, as outside demands on families have become much greater, with stresses consequently intensified, we have been servicing an increasing number of families who need help desperately; families whose problems are serious, of long standing, and consequently overwhelming; families in which the parents are immature, inadequate as parents, mentally ill or limited, and unable to cope with their ever-present day-to-day problems. With increasing frequency, we find that by the time these families become known to us their problems have been aggravated by repeated parental failures due to physical, economic, marital, and emotional problems.

As Beulah Compton has pointed out, "the emotional . . . development of children, still the prime function of the family, is the most complicated for parents to understand and cope with."³ This is all the more true when family life is complicated by parental failure and by the fact that the family's undesirable emotional climate—with resultant emotional damage to the children—is of long standing, and has developed to a crisis stage. The entanglement of the parents' inadequacies with the unacceptable behavior of their sick children makes it very difficult to begin service and be of real help.

It follows, then, that the agency's concern for the welfare of children must necessarily be reflected in expanded, more flexible service: service far beyond what a caseworker, carrying a full load of complex, involved, multiproblem families, can pos-

This article and the one which follows are based on papers presented at the National Conference on Homemaker Services, held in Washington, D.C., April 29-May 1, 1964.

sibly offer through brief visits to the family once, or even twice, a week; service which is imaginative, and derived from an ability to improvise and to cope with whatever one finds, whether poor housing, lack of food, lack of essential facilities, or the more difficult factors of parental immaturity, irresponsibility, indifference, and perhaps hostility, or serious physical illnesses and disabilities, mental illness, or mental limitations within the family group.

When giving protective service, one must sort out and weigh all these factors in relation to their effect primarily on the children. The question is, "How does one begin to cope with these long-entrenched problems?" and, more essentially, "How does one motivate and involve the parents to begin to help themselves and their children?"

The Caseworker-Homemaker Team

Obviously, the team approach of caseworker-homemaker is one workable answer, with homemaker service offered, and used, as an adjunct and supplementary service to protective casework.

A well-selected and supervised homemaker may in many family situations, fill the need for a substitute parent—a warm, accepting "other" adult who can be a benign maternal figure for the child and his immature parents. Being a part of the family interaction—8, 10, 12 hours a day, and at regularly scheduled intervals each week—the homemaker can help organize the household; wash and iron, to make it possible for the children to attend school; even wake them, give them a warm breakfast, and see that they make the school bus. She can mend clothes for the children, teach teenagers how to make their own clothes, and help mothers learn better household management.

But far beyond this, the homemaker can appraise the situation as it really is; understand what the family considers its most pressing problem and what its members feel they can do about it; and observe what, in fact, goes on. This factual information, colored with the sometimes intense feelings of the parents and overlayed with the homemaker's reactions and feelings, can be shared in conference with the caseworker, whose training, insight, and understanding of human behavior permits her, with her own knowledge of the situation, to make the casework decision essential to action and eventual improvement in the home.

In the caseworker-homemaker team, caseworkers and homemakers alike must assimilate certain convictions basic to the philosophy of protective services

and make them an integral part of their skills. If they are to do an effective job, both must be convinced that—

1. Most people have an innate capacity to be good parents and really want to be adequate.
2. There is an "inner core of positives" or strength in each person.
3. Parents do have the capacity to change.²
4. Parenthood is a privilege and can be a satisfying experience.
5. Children need mature, warm, and understanding parents.
6. Through well-timed interest and challenging parents can often use help given by the worker and homemaker and so begin to improve the care of their children.
7. The triad of worker-homemaker-parent is the most important tool in protective casework services—the closer the team and the family agree on what is needed and wanted, the more strength there is upon which to build.

The Homemakers

In our agency, homemaker service began nearly 10 years ago as a demonstration unit with two homemakers. We now have three full-time homemakers but see the need for many more. Yet, even with this limited staff, imaginative scheduling has made it possible to give a surprising amount of service. Since the program's inception, we have given homemaker service to 330 different families, involving 869 children. In the past year, we have served, per month, an average of 27 families, involving 106 children.

Our homemakers have been recruited from a number of sources: referrals from our own public assistance workers; persons suggested after interpretation of this program to the child welfare advisory committee or to civic groups in the community; response to newspaper ads.

In recruiting homemakers, we look for friendly, enthusiastic women who show a real interest in people and their problems. We want, preferably, married women who have raised their own children, thus having some background of experience in family living.

Our homemakers' formal education has ranged from sixth grade to 1 year of college. A hard-and-fast educational requirement seems unnecessary. More important are interest, eagerness to learn, patience, and tolerance of others' failings.

In our preliminary training, we have given the

homemakers a general orientation to the agency, including an introduction to the functions of the child welfare staff and to the homemakers' functions as part of "the casework team." Further orientation has included consideration of nutrition, household budgeting, and the meaning of food in relation to personal attitudes and cultural patterns; some discussion of normal child development—the care and behavior of babies, preschool children, school-age children, and adolescents; and some consideration of the relationship of the homemaker to an ill person, to parents, and to physically handicapped, emotionally disturbed, or mentally retarded children.

Additional training occurs on the job. This has involved the participation of the homemaker in case conferences about special problems, sometimes including persons outside the agency, such as the nutritionist from the St. Louis County Public Health Department. These conferences have proved invaluable in helping the homemakers understand and cope with different kinds of complicated situations. The homemakers have also participated in child-guidance clinic case conferences when a child they know is under discussion, thereby not only deepening their own understanding of the child but also, through their own observations of interactions in the home, contributing to the understanding of the professional staff. Occasionally, the homemakers have attended community workshops on child development and behavior and other appropriate subjects.

Our homemakers are covered under county civil service, have salaries on a five-step pay range, and have working hours, sick leave, and vacation time unparalleled to the social caseworkers.

The homemaker supervisor, a social worker, provides the homemakers with close supervision and constant interpretation. She provides a kind of liaison between the evaluation and plans of the family's caseworker (a child welfare worker) and the homemaker's activities and observations. The close working relationship between homemaker supervisor, child welfare worker, and homemaker imbues the homemaker with the conviction that, in her observation and individualization of the family members, her stimulation and motivation of the parents, and her ability to accept situations and families as they are, she is truly a member of a "team" strengthening family life. We have found that the homemaker needs continuing support, interpretation, and guidance to relate well to all members of a family without becoming personally overinvolved; and to maintain her own equilibrium in the midst of strained



"In recruiting homemakers, we look for friendly, enthusiastic women who show a real interest in people and their problems."

family relationships, the children's testing her out, and the emotional upsets of ill mothers and overburdened fathers.

With so few homemakers available (because of a shortage of funds), our agency has developed its own brand of imaginative scheduling and shuffling of homemaker assignments. Obviously, long-term placements are not possible, yet regular scheduling of certain days per week for consecutive weeks—and even months, if the situation warrants—is possible, and has, on the whole, seemed to meet the special needs of many families.

For example:

The members of a motherless family of eight children have tried hard, since the death of the mother, to accept a lonesome, insecure, and very dependent father who—when times become difficult—leans upon alcohol. Strong attachments and strengths in this home suggest that protective casework service—with the close help of a homemaker—may hold the home together for these children, and may begin to encourage the family to provide a better, more acceptable standard of living.

The homemaker goes into this home two to three times a week—from 3 to 6 p. m., after the children return from school. She goes particularly for the purpose of teaching the oldest girl, Mary, age 15, menu planning, cooking, and good housekeeping standards. Homemaking responsibilities for such a large, disorganized household seem far too much for Mary to handle alone, and she desperately needs the close support of both homemaker and caseworker.

After the death of her husband, 6 years ago, a mother of

three school-age children lost interest in herself, her home, and her children. Her housekeeping standards became progressively worse. She appeared depressed, withdrawn, and at times out of touch with reality, and she was unable to make any plans for her family. She seemed to be living in the past and made no effort to form any relationships in the present.

With the concerted effort of both homemaker and caseworker, this mother has occasionally "come out of herself" enough to work along with the homemaker in housecleaning, sorting out mounds of trash, discussing needed major repairs to the house, and even, with the homemaker's help, making curtains. The homemaker has tried not only to bring about enough improvement in the home to assure reasonable standards of health and comfort for the children, but also—through her observations—to help the caseworker evaluate the real capacity of the mother for caring for her family.

* * *

A very young emotionally disturbed mother of three preschool children, with no husband in the home, has been almost immobilized by the difficulties of managing on a meager public assistance grant. A visit from a homemaker for part of a day twice a week not only helps her get caught up on her housework and laundry, but also gives her a chance to take the children on an outing, to have them taken to the clinic, to call for and learn to use surplus foods, and sometimes just to get off by herself for a while. With the caseworker's help and the steady support of the warm, easygoing homemaker, this mother

is becoming less depressed, is learning to manage better, and is beginning to give the children a little much-needed individual attention.

Since "every unhappy family is unhappy in its own way,"⁴ how the caseworker-homemaker team functions in each family where children have been neglected or abused must be an individual caseworker decision. But more teamwork of this nature is necessary if the individual and complex patterns of family unhappiness, which have such devastating repercussions on children, are to be understood and alleviated.

¹ 60th Cong., 2d sess., U.S. Senate: Proceedings of the White House Conference on the Care of Dependent Children, held in Washington D.C., Jan. 25-26, 1909. In Senate documents, vol. xiii, 60th Cong., 2 sess. Washington, D.C. 1909.

² Scherer, Lorena: Protective casework service. *Children*, January-February 1956.

³ Compton, Beulah: Services to neglected children in their own home. Presented at institute given for child welfare services staff development at meeting of Missouri Division of Welfare, St. Louis. Feb. 27-28, 1962.

⁴ Tolstoy, Leo: "Anna Karenina."

HOMEMAKER SERVICE IN NEGLECT AND ABUSE

II. A Tool for Case Evaluation

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THE GENERAL PUBLIC, and even professional persons, find it difficult to believe that a parent will willfully and intentionally harm his child. Yet, not long ago, the New York papers carried headlines about a 7-year-old crippled child who was beaten to death by her mother and the mother's "boy friend" solely because "we enjoy beating her." Such incidents are not unusual, and have in recent years become the subject of nationwide concern.

As Elizabeth Elmer has said, there are ". . . im-

believably primitive transactions that take place beyond our gaze, safe from our curious questions."¹ These acts range from battering a child in impulsive rage to deliberate intent to murder. In such situations, the use of homemaker service to assist a social caseworker in the evaluation of family strengths and weaknesses, and to provide facts based on direct observation, can be invaluable in helping a responsible agency to take appropriate action for the protection of the child.

The value of the homemaker's role in clarification of the vague and uneasy impressions of hospitals and social agencies that there is need for intervention has been shown in many cases. Sometimes the homemaker has been the only source through which the actual facts have become known, enabling an agency to take court action.

Obviously, homemaker service is a resource which could be used increasingly by all communities to obtain a clearer picture of family relationships and incidents taking place in the home. Necessary action to protect children who are in danger has all too long been hampered by "the maze of contradictory statements and lack of real facts which so often surround cases of seriously neglected or battered children."²

This is illustrated in the case of Paul, age 9 months, who will never walk, and who has had four hospital admissions for injuries in his few short months of life. Yet he has been sent home again and again to become the repeated object of his father's rage and violence. Even when his father acknowledged the acts that resulted in Paul's becoming a hopeless cripple, the legal, medical, and social professions were reluctant to heed this family's unspoken appeal for Paul's protection.

Both Paul's parents are deaf-mutes. His father's history is full of evidence of frustration and rage over his inability to communicate and compete on a level with others. The parents met as adolescents on a social outing and were married after pregnancy with their first child occurred.

Although the father had occasional explosions of temper, he seems to have managed to sustain himself and his family without untoward incident until the conception of the second child, Paul. He then became so depressed that he lost control of his actions. This continued after Paul's birth, and worsened when Paul's mother proved to be totally unable to manage the two babies, less than a year apart in age. The father gave up his job and accepted public aid in order to remain at home to help his wife.

Outwardly, Paul's father seemed to be elated with the new baby, rocking him, kissing him, and holding him very tight. However, only 1 month after his birth, Paul was admitted to the hospital with a fractured skull. The parents reported he had been screaming and crying, and that his father, who was holding him at the time, accidentally dropped him on his head. Even before this, Paul had been treated for fractures, though not hospitalized.

Paul was treated and sent home only to be readmitted to the hospital at the age of 4 months, so badly beaten and bruised that he developed a spastic condition of both legs which will prevent him from ever walking. His father, who brought Paul to the hospital, admitted that the injuries occurred when he punched the baby in the abdomen.

At that point, the hospital reported the matter to the authorities. The father was arrested and admitted to a hospital

prison ward, where he remained for a month. He was then released on bail and returned home. His trial was postponed and later dismissed.

The point was made in a recent issue of CHILDREN that parents who neglect and batter their children are actually expressing their parental incapacities in action, and are asking to be stopped in their brutal behavior. Why else do they bring their injured children to hospitals, thus running a high risk of punishment?²

This was certainly true in the case of Paul's father, who asked for readmission to the hospital for himself because of depression and self-hate, which he admitted he displaced on the baby. However, he was diagnosed "not actively psychotic" and was released.

When Paul was sufficiently recovered to leave the hospital, he was once again discharged and taken home. This decision was made on the basis of his father's diagnosis, and because both parents had agreed to seek psychiatric help, along with social service and homemaker service.

Enter a Homemaker

By this time, several community agencies were interested in the family—the hospital, a psychiatric clinic, the family court, and the public welfare department. On a purchase-of-service agreement with the public agency, the Children's Aid Society, a voluntary agency, placed a homemaker with the family; she remained for 6 weeks.

The homemaker's observations proved invaluable in enabling the various interested agencies to obtain a clear picture of the family relationships, and to conclude that, without question, the child was in constant danger as long as he remained with his father.

The homemaker graphically described the father's handling of the baby: overfeeding him; hugging and kissing him so roughly that the baby often cried; shaking him violently when he did cry; giving him the bottle so forcefully that blisters were raised on his mouth.

The mother communicated with the homemaker by note and told her that the father stayed up late to watch television and that she was afraid to go to bed before he did because he might harm his son. On the other hand, the mother was unable to bring herself to make a formal complaint against the father.

Paul's parents did not follow through on the psychiatric referral. Therefore, on the basis of the homemaker's observations, a consultation between the children's agency providing homemaker service and the referring agency resulted in a decision to appeal to the court for the baby's permanent removal.

Later that same day, Paul was readmitted to the hospital suffering from a brain concussion. He had been dropped on his head by his father when he started crying during a feeding.

The case was referred to the family court and is still in process of investigation. Paul is in the custody of the court, pending decision.

Other Cases

The unique value of homemaker service in case evaluation, and even in casefinding, is illustrated in other family situations posing danger to children.

Such an example is the Grey family, with five children, age 5 and under. This family was referred to a protective agency by the pediatric clinic of a hospital because of the physical condition of the youngest child.

The homemaker—on 8-hour-a-day, 5-day-a-week assignment—learned that Mr. Grey, in his early thirties, had formerly been a compulsive drinker given to abusing his wife and family when drunk. He had joined Alcoholics Anonymous, and turned to this organization for his outside contacts, going from its meetings directly to his night job. He came home about 9 a.m., and slept most of the day, leaving Mrs. Grey to care for the children day and night on her own.

Her method of retaliation was to lock the children in the bedroom, so that they could not wander away. Often the homemaker would arrive in the morning to find the mother still in bed, and the locked-in children's physical needs completely unattended.

After 4 months, psychiatric consultation was scheduled. The psychiatrist felt that both parents were probably psychotic. The father was regarded as posing more danger to the children than the mother. His need to feel omnipotent was seen as the cause of his rages, during which he beat his wife and children.

The protective agency strongly urged court action to remove the children from the home.

Often the factor which precipitates a referral for homemaker service is one which is incidental to the total problem mosaic of the family, and extended observation and evaluation are needed. This is illustrated by the "Rivera case," which, after a year of homemaker service, still requires additional observations and tests before a suitable therapeutic plan can be made.

The Rivera parents are in their early twenties, their four children ranging in age from 4 years to a few months. Homemaker service was first provided to enable Mrs. Rivera to keep medical appointments at the center for her two younger children. She was unable to manage taking all four children to the clinic by herself.

The homemaker's observations made it immediately apparent that the family's problems were much greater and more complicated than they were originally thought to be. The mother alternated screaming at the children with bribing them to be good. She readily acknowledged that she had no control over them, and stated that both she and her husband wanted to place them in foster care so that they might work to pay off their debts. On the basis of these and other early impressions, full-time home-



"A . . . homemaker can . . . help many neglecting parents by . . . direct teaching by demonstration and example . . .

maker service was offered the family to help relieve immediate pressures and make possible further evaluation.

Soon after full-time homemaker service began, it became apparent that the situation was seriously complicated by the behavior of the 3-year-old child, described by his mother as having been "nothing but trouble" from birth. He was hyperactive, given to severe temper tantrums without apparent cause, enuretic, day and night, and was eating dirt, wood, and plaster. The parents agreed to a psychiatric evaluation of this child, which resulted in a tentative diagnosis of childhood psychosis with homicidal and suicidal tendencies. Hospitalization of the child, though urgently needed, was delayed owing to lack of inpatient psychiatric facilities for a child of 3.

Meanwhile, the home situation had worsened. The mother began to clean the house compulsively, sweeping the floor several times a day, washing the kitchen floor before lunch and again after lunch, and changing the children's clothing two or three times a day. Her moods alternated between silence and excessive talking.

She almost totally ignored the children, except to scream at them, push them, or hit them if they got in the way of her cleaning. If the homemaker had not been present, the mother would have let the children harm themselves, or each other, by her neglect. Two of the other children began to imitate the 3-year-old's tantrums and plaster eating.

On one occasion the mother became so enraged at a tantrum of the oldest child, a girl, that she took off her shoe and beat the child until the homemaker intervened. Later that day the mother said that she might have beaten the child to death had it not been for the homemaker. She made numerous references to children's deaths.

The psychiatrist's opinion is that this mother is either psychotic or reacting with abnormal behavior to the strain of the 3-year-old's behavior. A true

essment cannot be made until this child is removed, short- or long-term placement of all of the children may be indicated.

Grave Responsibility

We have been a long time in acting on the child welfare principle that children have an inherent right to the kind of care and nurturing that will enable them to grow up into healthy adults who will be able to give adequate care to their own children. The first step in such a procedure, and one which is immediately demanded by the uncovering of an alarming number of children in need of protection, is to find ways of obtaining the facts and acting quickly to protect those children whose lives are in danger. Helen Boardman has warned:

... Experiences with the repetitive nature of injuries indicate that an adult who has once injured a child is likely to repeat. Police warnings, court action, and probationary status have not been adequate deterrents. *The child must be considered to be in grave danger unless his environment can be proved to be safe.* The adult, too, needs protection from the consequences of his own explosive behavior.³

Yet, from the legal point of view:

The right of the parents to the care and custody of their children creates a strong presumption in favor of the parents in any proceedings to remove the child. Judicial decisions indicate that the conduct of the parents must amount to *forfeiture or abandonment* of their right to custody. . . .

In the face of these rights, it is obvious that any petition questioning removal of a child from his family must be based on solid and substantial reasons, established by plain and certain proofs of the neglect. The rights of parents are protected by tradition and precedent, and vague or ambiguous allegations will not be sufficient to show that the parent has forfeited these rights.⁴

Obviously, there is a need for clarification, early identification of the problem, and active steps toward solution.

Immediate authoritative action is needed in some instances to protect the life of the child in danger. In other instances, parents can be helped by a professional caseworker and a homemaker working in combination to achieve more healthy family relationships and to adopt better methods of child care, as

the preceding article by Louise Foresman makes clear. A homemaker can also help many neglecting parents by the direct teaching by demonstration and example which is so clearly in the homemaker's province. The placement of a homemaker, along with the services of the caseworker, can be invaluable in obtaining a well-rounded picture of the family dynamics and of the parents' actual or potential readiness to use help.

As has already been pointed out in CHILDREN,² many types of services are needed in combination to protect children from neglect and abuse. Homemaker service should be in the forefront of these. Morris and Gould have found that "services constructively engaging parents into society and putting them in contact with those who exercise nurturing parental roles are most effective in protecting children and in promoting social public health."⁵

Most important is the necessity of establishing the facts early in the child's life, not only to preserve his life but to use whatever forms of intervention can and should be used to alter the course when physical and personality damage is being inflicted.

Services must be provided long before the child enters school, for, by that time, it is often too late and the damage is often irreversible.

If we are to prevent the development of the kinds of personalities which can murder a President or, without reasonable provocation, murder his murderer, we must reach these personalities before the mold is set.

¹ Elmer, Elizabeth: Abused young children seen in hospitals. *Social Work*, October 1960.

² Morris, Marian G.; Gould, Robert W.; Matthews, Patricia J.: Toward prevention of child abuse. *Children*, March-April 1964.

³ Boardman, Helen E.: A project to rescue children from inflicted injuries. *Social Work*, January 1962.

⁴ Downs, William T.: The meaning and handling of child neglect—a legal view. *Child Welfare*, March 1963.

⁵ Morris, Marian G.; Gould, Robert W.: Role reversal: A concept in dealing with the neglected battered-child syndrome. In *The neglected battered-child syndrome: role reversal in parents*. Child Welfare League of America, New York. 1963.

... have you ever wondered how many fine scientists, doctors, musicians, authors, astronauts or spiritual leaders may have been lost to us because a child was neglected?

Esther Peterson, Assistant Secretary of Labor, at a meeting of the chairmen of the State day-care advisory committees, March 19, 1964.

BOOK NOTES

YOUTH ON THE STREETS: work with alienated youth groups. Saul Bernstein. Association Press, New York. 1964. 160 pp. \$3.95.

"A thesis of this book," writes the author, "is that the gap has become alarmingly great between youth at the bottom, the sub-lower class, and the respectable adult community, so great that it threatens to become the most important domestic problem in the United States." The book, an outgrowth of a study of work with youth gangs, deals with the causes and treatment of their alienation from society. Its author is professor and head of the group work department at Boston University School of Social Work.

Professor Bernstein gathered his material in nine major cities: Boston, Chicago, Cleveland, Detroit, Los Angeles, New York, Philadelphia, San Francisco, and Washington. He interviewed streetworkers, their supervisors and executives, judges, police officials, probation officers, psychiatrists, school officials, and researchers. He talked with members of street gangs and with some of the youths' parents.

How successful have social agencies been with these youngsters? In the area of private behavior—especially in relation to sex, drugs, drinking—while the responses were "far from completely negative," the author reports, "they were mostly discouraging." In the areas related to school and job, there were many examples of success, but, he says, not nearly enough.

The author concludes that the key role in working with delinquents is held by the streetworker, who faces "the challenge of helping to provide satisfactory substitutes for the excitement of fighting, stealing, and vandalism."

The author recommends that social agencies make a greater commitment to work with the poor, that streetworkers receive more professional training, that mass media tell the story to the public, that public officials respond more to the problem, and that more money be invested in combating it. However, he maintains that only the

whole community can remove the economic and social roadblocks to normal, healthy lives for these youngsters.

THE DEAF CHILD. Edith Whetnall and D. B. Fry. Charles C Thomas, Springfield, Ill. 1964. 237 pp. \$8.50.

This book is based on the principles and practice of the Audiology Unit of the Royal National Throat, Nose, and Ear Hospital and the Institute of Laryngology and Otology in the University of London.

The central theme is "the auditory approach to the training of deaf children," as developed at the unit since it began as the "Deafness Aid Clinic" in 1947. This approach, according to the authors, "depends on understanding the part played by the cerebral cortex in learning the associated skills of hearing and speech." The subject is approached from the viewpoints of both experimental phonetics and clinical otology.

The book was written primarily for doctors—otologists, pediatricians, health officers, and general practitioners. But the authors state that they hope "it may also be of value to child psychologists, hearing and speech therapists, and teachers of the deaf."

CHALLENGES IN MENTAL RETARDATION. Gunnar Dybwad. Foreword by Leonard Mayo. Columbia University Press, New York. 1964. 287 pp. \$6.

Among other subjects considered in this collection of writings by the former executive director of the National Association for Retarded Children are: the early education of the handicapped child, the family's role in caring for the mentally retarded, children and adults in residential care, the mentally retarded children who become delinquent, the rehabilitation of adult retardates, and community organization for the mentally retarded. An appendix by Rosemary Dybwad describes the development of parent-sponsored associations for mentally retarded children in other countries.

Dr. Dybwad maintains that no community in this country offers a well-rounded and quantitatively adequate program for the retarded.

He also maintains that of the billion dollars spent by all sources on the retarded, a disproportionate amount is spent on the 4 percent in institutions. Nevertheless, he points out, practically all States have long institutional waiting lists and the 150,000 available institutional beds are not nearly enough.

"Speaking quantitatively and qualitatively," Dr. Dybwad states, "no other service has as much to offer to the total group of mentally retarded as has the public school system." Of the million mentally retarded children in need of special programs in the public schools only about one-fifth are receiving such instruction, he maintains.

Stressing the importance of vocational training for the mentally retarded and of opportunities to develop self-reliance, Dr. Dybwad cites the workshops of the retarded in Holland as examples to be emulated.

"The key problem confronting parents of mentally retarded children is the need for competent diagnostic services," Dr. Dybwad maintains, and he stresses the importance of observing function: performance in clinical evaluation and re-evaluation of the child.

Research in Europe and the United States shows that severely as well as mildly retarded children have a distinct growth potential, he points out.

THE JOY OF CHILDREN. Text by Pearl S. Buck, with an introduction by Roy Sorenson, chairman of the National Committee for Children and Youth. The John Day Co., New York. 1964. 211 pp. Also for sale from the National Committee for Children and Youth, 1145 19th Street NW., Washington, D.C., 20036. \$7.50.

This volume is based on the photographic exhibit, "These Are Our Children," which was assembled by the Eastman Kodak Co. for the 1960 White House Conference on Children and Youth.

Divided into groups with chapter headings such as "For Every Child: Protection and Care; Security and Love," the 247 pictures and accompanying text portray not only the joys but also the sorrows and conflicts of childhood, adolescence, and early adulthood.

SOCIAL PROGRESS THROUGH SOCIAL PLANNING

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SOCIAL PLANNING was the 1964 "hit theme" in the international arena. UNICEF held a significant conference on "The Needs of Children and National Planning" in Bellagio, Italy, in April; United Nations agencies gave increased attention and technical assistance to national planning bodies in the developing countries; and the U.S. Agency for International Development gave evidence of increased awareness that our own foreign aid program must coordinate closely with a recipient country's planning efforts. It was timely, therefore, for the 12th International Conference on Social Work, meeting in Athens, Greece, in September 1964, to tackle the problem of planning, and it did so under the Conference theme: Social Progress Through Social Planning—The Role of Social Work."

Sixty-six nations were represented at the Conference by 2,300 delegates. The United States had more than 400 delegates in attendance; more than 50 delegates came from faraway Japan; and Latin America was well represented, with Brazil alone having more than 60. Practically every Western European country had substantial delegations and the Communist-bloc nations were represented by delegations from Yugoslavia, Czechoslovakia, and Poland. The developing countries of Asia and Africa were also represented.

Twenty-eight countries submitted "national reports" of activities in their own countries relating to the Conference theme; country case histories on planning activities were presented; in-

ternationally known experts delivered provocative papers; and some 40 study groups and commissions provided forums for intensive discussion.

The significance of such a Conference for the United States and for its children is, of course, difficult to assess. However, we are increasingly aware that in this shrinking world, ideas know no boundaries. International meetings create an "international vocabulary," open up channels of communication between professional personnel of the various countries represented, and through such means have a direct and indirect influence on all countries.

Dominating Notes

It is difficult to summarize briefly the hundreds of papers, reports, and sessions of the conference which bore on the planning theme. However, several notes dominated:

1. The growth of the "planning idea" has made *national* planning an important factor in the lives of people throughout the world. Widely recognized at the Conference, this assumption was spelled out in the report submitted by Pakistan: "There seems to be no escape from planning today. We hear of all kinds of planning: international planning; national planning; state planning; regional planning; area planning; local planning; space planning; economic planning; physical planning; social planning; integrated or comprehensive planning; sectoral planning; community planning; and even

the all-important, though controversial, family planning. Planning can be undertaken at all levels: local, state, or provincial, and national. Again, it can be undertaken both in the private sector and in the public sector."

2. In countries which do not have national planning boards or commissions, such as the United States and Germany, the rapidity of social change has necessitated long-range sectoral planning by the various agencies charged with responsibility for specific programs such as health, education, and agriculture.

3. National planning in most countries has emphasized economic goals. The developing countries, particularly, have concentrated on economic development and growth, increased production, a higher gross national product, and the like. Social factors have frequently been ignored until they have become serious problems.

4. Social planning must be integrated with economic planning, in order to prevent or mitigate many of the social problems which arise in both industrialized and industrializing countries, in both highly developed and still-developing countries.

5. More attention must be given by persons working in the social field to quantifying social needs, so that planners can assess costs and impact on the economy, and make judgments as to priorities.

6. In every country, priorities in so-

cial goals must be established. This is, of course, more important in less developed nations where resources are limited.

7. Social planning is influenced or controlled by the political structure and organization of the individual country. It was pointed out that although scientific developments may have a certain independence from the structure of the society in which they take place—for example, a moonshot can be developed by nations with diametrically opposed economic and political systems—social developments and programs are irrevocably tied to the structure of the country in which they take place. Thus, a country which philosophically rejects the concept of planning will approach social planning in an entirely different manner from a country which is conceived of as a completely planned economy.

8. Factual data necessary for social planning are frequently unavailable. Social research was reported to be lagging behind economic research even in highly developed countries. Stress was laid on the importance of research, not only for fact gathering but also for understanding the basic causes of the social dislocations and problems with which social planning and social welfare agencies must deal. There was agreement that a vast amount of pertinent, accurate, and systematized data is required for effective and efficient planning.

9. Today social agencies generally do not play an important role in social planning, although their knowledge of social problems would be valuable to planners and should be utilized. This was reported from countries all over the world.

10. The field of social work can make important contributions to planning because of the experience and knowledge of the persons working in this area.

11. Citizen participation in planning efforts is necessary, if such planning is to be understood and accepted. Such participation was stressed by representatives from nations differing widely in political ideology and structure. The consensus of the Conference on this

point was expressed in the report from Spain: "Planning is, by its very definition, a social matter, and this fact implies participation by the public, not only in the planning itself, but also in carrying out what has been planned."

12. The growth of social planning activities necessitates the training of personnel for planning tasks.

The foregoing is an indicative rather than a complete listing of general conclusions reached at the Conference.

Dr. Ellen Winston, Commissioner of Welfare, U.S. Department of Health, Education, and Welfare, summarized the sense of the Conference well when she asserted that "the concept of development, of the deliberate ordering of resources to assure a better life, is the rallying call of our time throughout the world."

Implications for This Country

What are the implications of this Conference for the United States and particularly for the 70 million children of our country? What can we, in our prosperous and well-developed Nation, learn from this exchange of experiences with representatives of the world community of nations? Many valuable facts and ideas emerged which can be of value to those of us concerned with social problems in the United States. For example, it was made clear that—

1. The social problems we face in this country, such as juvenile delinquency, unmarried parenthood, family disorganization, migration from rural to urban areas, and others, are worldwide. Our attention, therefore, needs to be focused on fundamental causes and not only on factors indigenous to the United States.

2. The necessity of husbanding limited resources in the less affluent countries has forced these countries to study social problems in order to establish priorities. Since we in the United States are becoming increasingly concerned with the problem of priorities in goals, the experiences of priority setting and planning by other countries deserve study on our part.

3. In the scramble for a greater share of a country's resources by various

groups for their special interests—schools, health agencies, businesses, roads, and others—the interests of non-vocal groups of the population, such as children, may not obtain their appropriate share. How can such interest be protected and considered in the planning of social programs? Although the experiences of many countries may not be applicable to the United States we must be alert to any that are.

4. In rapidly developing societies problems which are ignored can be costly and damaging. When we see the catastrophic results of lack of planning for the increase in the school population in other countries, and when we realize that the number of college students in the United States may increase by 1970 from the present 4 million to 7 million, we may be impressed with the importance of immediate planning. And as we examine the programs of other nations, we realize that infant mortality in this country is still higher than in the United Kingdom, Sweden, Australia, Norway, Switzerland, Denmark, and several other countries, perhaps our efforts to improve the lot of American children may receive greater impetus.

The International Conference on Social Work in Athens revealed again the leadership of the United States in many areas. It also demonstrated that the unique and indigenous developments in other countries may contribute to our understanding of problems here and of value in our own social programs.

Many of our social institutions have had their roots in the developments in other countries—for example, much of the pattern of our social insurances was borrowed from Germany, and our basic ideas of public assistance were inherited from the poor laws of Great Britain.

The recent meeting of the International Conference on Social Work has demonstrated that today the social developments of many countries bear promise of making contributions to the solution of many current social problems, and that we in the United States can learn from other nations as well as contribute to their social development.

EFFECTS OF ADOPTION ON CHILDREN FROM INSTITUTIONS

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THE National Institute of Mental Health is presently carrying on three followup studies of adults who were reared away from their own parents. The purpose is to determine the adult status of children previously studied by the Iowa Child Welfare Research Station, State University of Iowa, in cooperation with the Children's Division, Iowa Board of Control of State Institutions, which initiated studies of intervention in infancy or early childhood. These include followup studies of—

I. A longitudinal study of 100 adopted children.¹ The followup of this study is being carried on by the original investigators.

II. A study of the effects of differential stimulation on mentally retarded children.² The followup of this study is also being carried on by the original investigator.

III. A study of the mental development in adoptive homes of children whose biological mothers were mentally retarded.³ The followup of this study is being carried on by Lowell W. Shenke, psychologist, Iowa Board of Control of State Institutions, with one of the original investigators (the writer) serving as consultant.

In all three of these studies, the children selected for study were considered to be biologically sound and without demonstrable abnormality as determined through diagnostic evaluation by competent pediatricians. With the inclusion of the present followup

studies, they cover a life span of 30 years, the present ages of the subjects being within a range of 25 to 35 years.

Adopted Children

In regard to the followup of Study I, all adoptive parents and adopted children have been located after a lapse of 16 years since the last contacts of the earlier study. Interviews with adoptive parents and their adult adopted children are nearing completion. Analysis of the data will start in the near future.

Preliminary indications are that these adoptive children as adults are achieving at levels consistently higher than would have been predicted from the intellectual, educational, or socio-economic level of the biological parents, and equal to the expectancy for children living in the homes of natural parents capable of providing environmental impacts similar to those which have been provided by the adoptive parents.

Mentally Retarded Children

In regard to followup of Study II, all subjects have been located after a lapse of 21 years, all interviews completed, with the data presently being processed.

Preliminary findings of this followup study are particularly startling. In the original study, 13 children in an experimental group, all mentally retarded at the beginning of the study, were at an early age transferred from one institution to another which provided a much higher degree of one-to-one emotional relationship between

mother-surrogates and the children. Later, 11 of these children were placed in adoptive homes.

A contrast group of 12 children, initially at a higher level of intelligence than those in the experimental group, remained in a relatively nonstimulating institutional environment over a prolonged period of time. In the initial study, the children in the experimental group showed a decided increase in rate of mental growth, whereas the children in the contrast group showed progressive mental retardation.

In the adult followup study, the two groups continued to be remarkably divergent. All 13 children in the experimental group are self-supporting, and none is a ward of any institution, public or private. Eleven of the 13 children are married, and 9 of these have children.

Of the 12 children in the contrast group, 1 died in adolescence following continued residence in a State institution for the mentally retarded; 4 are still wards of institutions; 1 of these is in a mental hospital, and 3 are in institutions for the mentally retarded. Among those no longer wards of institutions, only two have married, and one of these is divorced. Two of the four females in the contrast group were sterilized in late adolescence to preclude the possibility of procreation if later placed out to work.

In education, disparity between the two groups is great. In the experimental group, the median grade completed is the 12th; in the contrast group,

the 3d. Four subjects in the experimental group have had one year or more of college work, one of the boys having received a B.A. degree. Occupationally, the experimental group ranges from professional and semi-professional positions to semiskilled labor or domestic work. In the contrast group, 50 percent of the subjects are unemployed, and those that are employed are, with the exception of one person, unskilled laborers.

One girl in the experimental group who initially had an IQ of 35 has subsequently graduated from high school and taken one semester of work at a college. She is married and has two boys. These boys have been given intelligence tests and have achieved IQ scores of 128 and 107.

If this girl had had the continuing experience characteristic of those in the contrast group, she would have remained all these years on a custodial ward in an institution for the mentally retarded, or have been sterilized in late adolescence or early adulthood and subsequently placed out on a nonskilled labor type of domestic employment.

In fact, "but for the grace of God," any one of the cases in the experimental group might have experienced the impact of deprivation of those in the contrast group, and vice versa.

Cost to the State

We are also studying the cost to the State of each subject in the experimental group and the contrast group of Study II—based on information as to per capita cost for institutional care per month or year for each of the years from 1932 to 1963. Preliminary indications are shocking.

In the experimental group the median total cost is less than \$1,000, whereas

in the contrast group it is 10 times that, with a range from \$7,000 to \$24,000. One case in the contrast group can be cited of a person who has been a ward of the State institution for over 30 years. The total cost to the State in this instance has been \$24,113.

In the 1930's, the monthly per capita cost at State children's institutions and at mental hospitals ranged around \$17 per month. This has progressively increased over the years until the present figure is considerably more than \$200 per month. We can speculatively extrapolate on the cost to the State of the subjects in Study II had our comparisons started in 1963 instead of 1932. Assuming that costs were constant from 1963 to 1993, the case in the example cited would have cost the State \$100,000.

Mentally Retarded Parents

As already mentioned, Study III involved children whose biological mothers were considered to be mentally retarded. The children had been separated from their natural mothers in early infancy, either by voluntary release or by court commitment, and had been placed in adoptive homes before they were 2 years old. The study included a total of 87 cases. IQ scores were obtained on each of the mothers, none of whom achieved higher than 75. The range extended down to an IQ of 32.

After a time interval of 21 years, efforts are under way to locate the adoptive parents and children of this study, and indications are that all or most of them will be found. Several interviews have already been completed.

In the followup, in addition to securing information on the adult status of the children, intelligence tests are being

administered to the second generation—the grandchildren of the mentally retarded, biological grandmothers.

Preliminary findings in this followup study suggest that the first generation (the children of the original study) compares favorably in occupational status as adults with the Iowa population of comparable ages according to 1960 census figures. The second generation children are scoring average and above on intelligence tests.

Some Implications

Since the preliminary findings of these three followup studies are substantiated by reports of many supporting studies published in the past 2 years, it would seem that we have adequate knowledge for designing programs of intervention to counteract the devastating effects of poverty, sociocultural deprivation, maternal deprivation, or a combination of these ill. This means making expenditures for prevention, rather than waiting for the tremendous costs of a curative nature. It does not, of course, preclude further research and exploratory studies to determine the optimum modes of intervention and the most appropriate age for initiating such procedures.

¹ Skodak, Marie; Skeels, Harold M.: A first follow-up study of one hundred adopted children. *Journal of Genetic Psychology*, September 1949.

² Skeels, Harold M.; Dye, Harold B.: A study of the effects of differential stimulation on mentally retarded children. (Proceedings and addresses of the American Association on Mental Deficiency.) *Journal of Psycho-asthenics*, v. 44, no. 1, 1938-39.

³ Skeels, Harold M.; Harms, Irene: Children with inferior social histories; their mental development in adoptive homes. *Journal of Genetic Psychology*, June 1948.

The discoveries being made in prevention of mental retardation and methods of bringing forth the potential in these children will do no one any good unless they are put to work in the local communities where the children live.

From the 1963 report of the Child Welfare Division, Colorado Department of Public Welfare, Denver.

IN THE JOURNALS

Poverty

The average total income per person (the 4 million people in the Federal-state program of aid to families with dependent children (AFDC) is \$1.15 a day, a figure derived from 1961 data analyzed by Gerald Kahn and Ellen J. Raskin in *Welfare in Review* for October 1964. ("Families Receiving AFDC: What Do They Have To Live On?") This daily \$1.15—about \$35 per recipient per month and \$140 for a family of four—must cover costs of food, shelter, fuel and light, clothing, personal care, transportation, school expenses, and other daily living requirements.

Thus the annual income from all sources of families receiving AFDC averages \$1,680, little more than half the \$3,000 figure used as the poverty incarceration line by President Johnson in his message on poverty.

"Of all public assistance recipients, AFDC families receive the least adequate public assistance payments" and fall furthest behind in progress in American standards of living," the authors report. For example, during the year period 1958-61, the annual income of AFDC recipients increased \$36 a person, while the average per capita income for the Nation as a whole went up \$34 every 6 months.

The authors point out that nearly half of all AFDC families have some unmet need under their State's own standards of minimum living costs; for one-third of the families this unmet need comes to \$30 or more a month; for most 3 percent, to \$100 or more a month.

Foster Home Variables

Based on a study of the records of the Montreal children's agency—the Children's Service Centre—H. B. Murphy, McGill University psychiatrist, included in the quarterly *Mental Hygiene* for October 1964, that suburban foster homes "achieve . . . much better results" than urban or rural

foster homes, regardless of the sex or family background of the children placed in care. ("Foster Home Variables and Adult Outcomes.")

This study was the second in a series by Dr. Murphy, the first of which reported on 316 cases taken from the same agency. ("Natural Family Pointers to Foster Care Outcome," *Mental Hygiene*, July 1964.)

The second study reports on the foster-home histories of the 114 cases among these 316 whose natural backgrounds seemed to indicate the poorest prognosis, plus an additional 82 children, for comparison, whose natural backgrounds were apparently more favorable.

Although expecting that favorable adult outcome would depend on such factors as avoidance of multiple placements, a warm and loving foster mother, and clarity in explaining to the child his relationship to the various adults around him, the author concluded that the "variable which proved most strongly associated with outcome" proved to be the residential location of the foster home. "Poor risk" children spending their longest foster stay in a suburban home were shown to have a much higher percentage of unsatisfactory outcome than those spending their stay in either a city or a rural home.

Followup of Prematures

Some findings of a followup study of children born prematurely in a large municipal hospital serving families of low socioeconomic status are reported in the October 1964 issue of the quarterly *Social Work*. ("Development of Lower-Class Premature Children Born In and Out of Wedlock," by Helen Wortis, Rhoda Cutler, Rose Rue, and A. M. Freedman.)

The study involved 249 Negro children who weighed 2,100 grams or less when born at the Kings County Hospital in Brooklyn, N.Y., and who were followed through the premature clinic for 2½ years.

Findings on the child's developmental

status and social situation at age 2½ were analyzed in relation to the mother's marital status at the time of his birth. While there was a high incidence of neurologic abnormality in the total group of children, no significant relation was found between the incidence of neurologic abnormality and the mother's marital status. In regard to social situation, however, the children born out of wedlock were reported as "more often separated from parents, more likely to be dependent upon public assistance and to have a working mother." On the other hand, the investigators found no difference by marital status of the mother in the quality of care a child was receiving at 2½ years.

Varied Roots of Delinquency

"What is a juvenile delinquent?" asks William C. Kvaraceus, Ph. D., in an article in the quarterly *Federal Probation* for September 1964, pointing out the differences from country to country in definitions of delinquency and in points of view on what should be done about it. ("Juvenile Delinquency: A Problem for the Modern World.") He maintains that in almost every city in the world an important element in the overall pattern of juvenile delinquency is the juvenile gang, and that serious acts of delinquency are being committed by the sons of the rich as well as of the poor.

The author cites three case stories to make the point that "delinquents often do the same thing for vastly different reasons." He recommends checking several scientifically evolved theories in dealing with each individual delinquent "apart from his conspirators." These are theories having to do with reactions to home life, school problems, relationship to parents, self-image, and personality, as well as those concerned with the patterns of behavior and the frustrations of the neighborhood milieu. The author's theme: "There is not one cause for delinquency but rather a sequence of interlocking factors in the child's life that can result in delinquency."

Dealing with the problem of delinquency, the author asserts, must be a concern of the whole community, involving not only schools, police, courts, job-training and employment services, but also the parents of delinquents and the delinquents themselves.

HERE AND THERE

Against Delinquency

Three grants, each of a different type, were made late in 1964 under the Juvenile Delinquency and Youth Offenses Control Act of 1961. (See "Federal Legislation," CHILDREN, November-December 1961, p. 232.) They were:

- A community demonstration grant of \$1.5 million to the United Planning Organization (UPO), in Washington, D.C., an organization incorporated in December 1962 to provide opportunities for youth in the District of Columbia, and recently designated as coordinator for the "war on poverty" in the District. The grant is the first portion of \$5 million to be awarded under a special provision of a 1964 amendment to the act for a delinquency prevention demonstration program in the Nation's Capital. The money will be used to carry out the plans made by Washington Action for Youth (WAY), a division of UPO, for a multifaceted project in the low-income, densely populated Cardozo area of Washington, part of which had already been put into operation with the support of a pilot demonstration grant. (See "For Youth," CHILDREN, November-December 1963, p. 242.)

The UPO project includes: a youth employment program, with emphasis on training, placement, and on job development; a neighborhood development center providing community organization, consumer education, and services—credit union, legal aid, and family counseling; residential facilities—halfway houses, shelters, group foster-family homes for children and youth needing care away from home; day-care centers for preschool children; research evaluation.

- A training grant of \$50,216 to the University of Hawaii, for the first year's operation of a 3-year experimental delinquency control and prevention training center at the university. The center will develop comprehensive and specialized programs for the further training of teachers, social workers, law enforcement personnel, and others who work with youth; test the applicability of techniques of delin-

quency control developed elsewhere and supplement these with others to be developed locally; train volunteers to work with underprivileged youth; develop training materials; and carry out evaluative studies. The center's faculty will be made up of persons from the fields of sociology, social work, education, psychology, political science, and other related disciplines.

- A new type of short-term demonstration grant, the first of a number to be made for direct service to delinquents or potential delinquents. The grant of \$43,297 went to the University of California at Berkeley for work in the public schools to build on the strengths, cultural and personal, of children identified as troublesome by their teachers.

Rights of the Poor

The need for a team approach between lawyers and social workers to protect the legal rights of the poor received strong emphasis in the discussions of a 3-day conference on the extension of legal services to the poor, held in Washington, D.C., in mid-November under the auspices of the Office of Juvenile Delinquency and Youth Development, Welfare Administration. Of the 158 participants, about two-thirds were lawyers, many of them on the faculties of law schools or schools of social work, and the rest were social workers or persons closely connected with the work of social agencies. While recognizing the differences in perspective and training that create misunderstandings between the two professions, they considered the possibilities of working more closely together to use the law as an instrument of social change and protection.

In welcoming the conferees, Ellen Winston, Commissioner of Welfare, pointed to three reasons why it is important to find more effective methods of meeting the legal problems of the poor: (1) In many communities, measures for helping the poor with their legal problems are meager or nonexistent; (2) lack of educational advantages makes many poor people susceptible to injustice and exploitations;

(3) with the growth of the population and resultant increasing complexity of laws and regulations, there are more occasions to need legal services.

Throughout the conference, repeat references were made to the fact that many of the poor are kept poor because they do not know their legal rights in relation to such problems as installment buying, landlord-tenant differences, public welfare administration.

"The poor," said Acting Attorney General Nicholas deB. Katzenbach, in the luncheon meeting, "need advocates not simply to present their side of the story but to give them hope, to demonstrate that the law is not an enemy, but a guardian, and that public officials are not their masters, but their servants."

Panel presentations and discussions from the floor and in three working groups revealed considerable interest in community experiments in (1) providing aggressive neighborhood-based legal services and in (2) law school experiments in providing legal services to the poor through supervised student "interns."

The neighborhood-based legal services go beyond the usual community-supported legal aid service, it was pointed out, by making efforts, through a lawyer-social worker partnership, both to find cases needing legal help; to prevent the need for such help by educating the people in the neighborhood as to the requirements of their rights under laws and regulations which affect their daily lives.

The use of law student interns was described not only as a needed extension of legal services to the poor, as a valuable method of interest young lawyers in social problems and social needs.

Frequent reference was made to need on the part of both lawyers and social workers for training in the basic goals and philosophy of each other's profession.

The misunderstandings of social workers and lawyers usually occur, it was maintained, because of the failure of lawyers to understand the weakness of the adversary system in dealing with social problems, and the failure of social workers to adhere to the rules of evidence when serving as factfinders in the court. The adversary system, it was charged, fails to protect children who are used as pawns in divorce proceedings, and is abrogated completely.

juvenile courts, "where the child's only hope that the truth will be brought rests on the social worker."

Full proceedings of the conference will be published in the near future by the Office of Juvenile Delinquency and Youth Development.

Training Opportunities

A 3-year career development program in maternal and child health for physicians, leading to certification by the American Board of Pediatrics as well as to a degree of master of public health, has recently been initiated by the University of California School of Public Health at Berkeley in conjunction with the pediatrics department of the university's medical school at San Francisco and the medical schools of Oxford University and the University of Washington. Fellowships are provided by the Children's Bureau.

Two other new training programs recently initiated by the University of California School of Public Health at Berkeley are:

- A 12- to 17-month training program in school health for physicians, nurses, and health educators. The program is offered by the school's Divisions of Maternal and Child Health, Public Health Nursing, and Health Education. Fellowships funded by the U.S. Public Health Service are available.

- A 2-year educational program in mental retardation and related conditions, sponsored by the Children's Bureau, to train pediatricians to "plan, direct, administer, and operate community services for children with mental retardation and associated abnormalities." The program is divided into two parts: 9 months at the School of Public Health where the student majors in maternal and child health; 15 months of intensive clinical training in a variety of clinical services in the New York Area. Fellowships are available.

Polio Reductions

Marked decreases in the incidence of poliomyelitis in an 11-year period (1951-62) covering the introduction of polio vaccine are shown by figures recently released by the World Health Organization for 28 countries which report the disease to WHO.

In the decade between 1951 and 1961, polio case reports in Norway decreased by 97 percent—from 2,233 to 66; in the same decade, cases in the United

States declined by 95 percent from 28,386 cases in 1951 (and 57,879 in the epidemic year 1952) to 1,312 in 1961.

For other countries with a high incidence of cases in 1952, comparisons are given with 1962 reports: Denmark, with 5,676 cases in 1952, dropped to 11 cases in 1962; the Federal Republic of Germany, from 9,510 to 201; New Zealand, from "almost 900" to 3.

Reductions from 1951 to 1962 noted in the report are: Mexico, 1,831 to 183; Israel, 918 to 16; Japan, 4,233 to 287; Australia, 4,736 to 435.

Not one case was recorded in Czechoslovakia in 1961 or 1962, although 1,071 cases had been recorded there in 1957. Canada, which had 8,888 cases in 1953, had 89 cases in 1962. Switzerland, with 1,628 cases in 1954, had 12 cases in 1962.

Although the general trend in incidence was downward, two countries reported increases. In the United Arab Republic, the only African country reporting, cases increased from 18 in 1951 to 234 in 1962, with peaks in 1955 and 1958. In Ceylon, there were 212 cases in 1951 and 1,052 in 1962. In both countries, vaccination campaigns are in progress.

The WHO report warns against comparing the figures from different countries, since, because of its wide range of symptoms, poliomyelitis is not always recognized and since some countries report only cases with paralytic manifestations.

Day Care

A 3-day National Conference on Day Care Services is to be held in Washington, D.C., May 13-15, 1965, under the sponsorship of the National Committee for the Day Care of Children and the Child Welfare League of America, in cooperation with the Children's Bureau. The conference is designed to interpret the day care of children as an essential community service for strengthening and maintaining family life, and to promote community action throughout the country for the development of day-care services. Representatives of business, industry, labor, and professional groups in a position to influence the development of day care are being invited to attend.

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A general lack of awareness of the State child-care licensing program was found among employed mothers inter-

viewed in a recent survey of day care arrangements and needs in Topeka, Kans. The survey was sponsored jointly by the Division of Maternal and Child Health, Kansas State Department of Health, and the Topeka Welfare Planning Council. Information was gathered through interviews with a selected sample of families from all parts of the city; and through inquiries to agencies serving families and children.

Other findings were that

- Among children of working mothers, the largest group consists of those cared for by relatives; the second largest, of unsupervised school-age children.

- A greater proportion of Negro children than white children need day-care services and such services are less available to them.

- Many handicapped or culturally deprived children known to social agencies need experiences away from home, which they are not now getting.

The study recommends: the extension or expansion of day-care services of all types—part-time and full-time care for preschool children, foster family care for children under 3, after-school care for school-age children—with subsidized care being made available in low-income neighborhoods; special efforts to educate the public about the child-care licensing program; and the establishment of an inter-agency board to arrange for appropriate day-care placement of individual handicapped or culturally deprived children.

The report of the study, "Day Care of Children: a Survey of Day Care Needs in Topeka, Kansas," is available from the Division of Maternal and Child Health, Kansas State Department of Health.

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A project to demonstrate and assess the usefulness of social casework in connection with day-care service is under way in Worcester, Mass., under the sponsorship of the Catholic Charities of the Diocese of Worcester. The project is being supported by a grant from the Massachusetts Division of Child Guardianship with the use of Federal day-care funds made available through the Children's Bureau.

By placing social caseworkers for 8 months in two day-care centers to provide direct, consultative, and educational services and, at the end of the

period, eliciting observations from day-care personnel and parents, the project will attempt to identify and evaluate: (1) methods for interpreting the values of casework service to day-care personnel and parents using day-care service; (2) the range of other social welfare services required by families using day care; and (3) alternative ways of organizing social services for families using day care. One of the day-care centers participating in the study is an agency-sponsored center; the other is a commercial venture.

The service aspects of the project, which got under way in September 1964, are scheduled for completion by June 1965.

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A national survey of the child-care arrangements made by working mothers will be conducted by the Bureau of the Census in February 1965 as part of its monthly Current Population Survey. Jointly sponsored by the Children's Bureau and the U.S. Department of Labor, Women's Bureau, the survey is planned to update a similar survey sponsored by the Children's Bureau in 1958. (See "Day Care," *CHILDREN*, March-April 1959, p. 77.) While the 1958 survey included only children under 12 whose mothers were working full time, the new survey will include children up to 14 whose mothers are working either full or part time.

Child Welfare Research

Differences between home and day-care settings may have more significant developmental effects on children who experience day care, than differences between the child-rearing practices of mothers and of day-care personnel, according to an exploratory study recently made in Los Angeles County, Calif. The investigators suggest that the regulatory features inherent in group care offer fewer opportunities than do home settings for children "to test the limits of their skill and competence, to reject temptations, to observe adult roles, or to talk with adults." They found marked similarities in child-care goals among mothers and day-care personnel, although some differences—especially between the centers and mothers of low socioeconomic status—in attitudes toward timing and initiative and in training and enforcement patterns.

The study, "Children in Group Day Care: The Effect of a Dual Child-Rear-

ing Environment," was undertaken by the Welfare Planning Council of the Los Angeles Region, with Federal funds from the Children's Bureau. Its purpose was "to develop a more precise formulation of those elements which determine the outcomes of day-care experience for preschool children."

The investigators sought answers to three questions: (1) What alterations in the child-rearing environment occur for all children who are placed in group day care? (2) Are the alterations greater for some children than for others because of their family backgrounds? (3) To what extent does the choice of a particular type of day-care center alter the child-rearing environment?

From the 396 day-care centers which in Los Angeles County provide full-day care for children of working mothers, 30 were selected for observation by the investigators. These were chosen on the basis of their type of sponsorship (public, private nonprofit, or commercial) and the socioeconomic and dominant ethnicity of the neighborhoods, so that they would be representative of the various types of centers in the community.

Interviewers questioned 219 mothers and 67 teachers as well as the centers' 30 directors.

In analyzing the results, the investigators divided the parents into four groups according to socioeconomic status (SES) based on combined ratings of mother's education, mother's occupation, and total family income. The centers, and the parents, were also classified according to "climate": warm nonauthoritative; warm authoritative; cold nonauthoritative; cold authoritative.

Among many other findings, the investigators report that:

- Parents on the whole are more likely to punish by spanking, whereas teachers are more likely to use restriction as a method of enforcement; teachers place more restriction on noise than do parents.

- Teachers as a group have higher standards than parents for neatness and table manners, and place more emphasis on the care of property. Parents have higher standards for their children in areas of behavior with "moral connotations"—sexual curiosity, bad language, aggression.

- Parents, especially those of low

SES, expect children to obey more quickly than teachers.

- Authoritative mothers frequent place their children in nonauthoritative centers; and nonauthoritative parents often place their children in authoritative centers.

- Parents with the lowest demands for independence (low SES parents) are most apt to place their children in "cold" centers, where demands for dependence are high.

- The director's educational attainment appears to have important consequences for the center's climate, if program development, the quality of supervision, and sureness in administrative leadership. Well-educated directors are most apt to have warm, but not necessarily well-educated, persons working under them as teachers.

- Program and climate in centers appear to be responsive to the presence or absence of parental demands and expectations. When parents expect nothing more than custodial care, the program is likely to drift in that direction.

- Mothers' usual "intuitive" child-rearing patterns often appear to be disrupted when contact with the child telescopes into a small portion of the day. Low SES mothers who work tend to have fewer opportunities than working mothers of higher SES to be with their children, since they place the children in group care at a younger age and the children remain in care longer hours.

- Low SES homes are less apt to provide the child with the dimensions of experience which seem to be lacking in group care—especially opportunities to develop initiative and language skills.

Against Measles

The U.S. Public Health Service has begun immunization against measles for 4,500 Alaska native children (Eskimo, Indian, and Aleut) under 4 years of age using the new "live attenuated" vaccine, which is expected to immunize for life. This is the same vaccine being used in the program to immunize 1 million African children being conducted in six West African countries, with the assistance of the Agency for International Development. (See "Vaccines," *CHILDREN*, November-December 1964, p. 243.)

The Alaska program got under way

ly 1964 and is expected to be completed by June of 1965.

USPHS staff are assisted by nurses in the Alaska State Division of Public Health under a contractual arrangement with the Federal agency. Health teams take off by bush or chartered planes from one of the seven Alaska native hospitals operated by the USPHS. After the planes land, the medical supplies often are transported from village to village by dogsled, skin boat, and/or cart.

Measles is the leading contagious disease among Alaska native children, who tend to suffer more severely from various complications than do most other American children.

In the development of the live attenuated vaccine, children of both Africa and Alaska played an important part. In last year's pilot programs to test the newly developed live vaccine, skimo children in the villages of Cooper Bay and Chevak in the Bering Sea coastal area near the Arctic Circle participated, while children in the villages of Upper Volta, near the Equator

Africa, were doing the same. (See "About Vaccines," *CHILDREN*, July-August 1962, p. 166.) The vaccine was licensed by the U.S. Public Health Service for commercial output on March 21, 1963. (See "Vaccines and Drugs," *CHILDREN*, May-June 1963, p. 121.) Following completion of the initial measles immunization programs in Alaska, measles vaccination will become a part of the USPHS's regular inoculation program for Alaska native children, which now includes immunization against polio, smallpox, influenza, diphtheria, whooping cough, and tetanus.

Child Health

The importance of early health care to the later health of children and youth is emphasized in a report of the health care of school-age children, submitted to President Johnson late in November by Secretary of Health, Education, and Welfare Anthony J. Celebrezze, as the result of a request made by President Kennedy in his youth message, February 14, 1963.

Prepared by the Children's Bureau, in cooperation with the Office of Education, the Public Health Service, and the Office of the Commissioner of Welfare, the report presents data on the prevalence of illness and handicapping

conditions among children of various ages and economic groups, and on the availability and use of medical facilities for their care, and describes changing concepts of school health services.

Pointing out that the roots of many health problems among school children reach back to early years of childhood in an environment of emotional, intellectual, and economic deprivation, the Secretary in his letter of transmittal stressed six areas of needed action revealed by the report. In brief, they are:

- The resources of agencies concerned with welfare, health, and education should be brought to bear on the child's problems early in the preschool years.
- Renewed emphasis should be given to clinics providing child health supervision, with experimentation in the most effective use of physicians, public health nurses, and others.
- Programs should be developed to test the effectiveness of different methods of identifying children with health problems.
- Comprehensive screening projects encompassing several schools should be developed and clinics be made available to which children, with their parents, can be referred.
- Greater emphasis should be placed on health programs for children in secondary schools, especially through the development of clinics for adolescents.
- Studies and demonstrations should be made to test methods of reaching and screening preschool children for vision and hearing problems.

The report, "Health of Children of School Age" (Children's Bureau Publication No. 427, 1964), is available from the Superintendent of Documents, Government Printing Office, Washington, D.C., 20402; price, 25 cents.

Mental Retardation

In mid-November, the Children's Bureau announced grants totaling \$1,456,736 for 15 projects in maternal and child health and crippled children's services, the second group of awards made under the increased appropriations and new programs authorized by the 1963 Maternal and Child Health and Mental Retardation Planning Amendments to the Social Security Act. (See "Health Grants," *CHILDREN*, September-October 1964, p. 199.)

Included is a grant of \$826,575 to the Puerto Rico Insular Department of Health to establish a program of prenatal, delivery, and post-partum care for mothers and infants in the island's Ponce area—the eighth project in the new maternal and infant care program.

Of the remaining 11 grants, 10 were made to provide special training for physicians, nurses, and occupational therapists in pediatric care and mental retardation; and 4 to provide additional clinical services for children with mental or physical defects, or both. They went to 11 universities, a city health department, a children's hospital, and a State school for the retarded.

In mid-October, the Public Health Service awarded the first two of a number of Federal grants for construction of large-scale mental retardation research and training centers under the provisions of the "Mental Retardation Facilities and Communities Mental Health Centers Act of 1963." The recipients were the University of Washington School of Medicine in Seattle (\$6,040,000) and the Albert Einstein College of Medicine of Yeshiva University in New York (\$3,750,000).

The grants will provide about 75 percent of the anticipated cost of constructing the two centers, which are expected to be completed in 1968. Each university has pledged that it will use its center for research and training for 20 years.

A national advertising campaign to alert the public to the needs and potentials of the mentally retarded was launched late in 1964 under the joint sponsorship of the Joseph P. Kennedy, Jr. Foundation, the U.S. Department of Health, Education, and Welfare, and the Advertising Council, a private, non-profit, public service organization supported by business groups. The campaign began with the distribution of "advertisements" and spot announcements prepared by the Advertising Council to newspapers and to radio and television stations, to be carried as a public service. Costs of preparing and distributing the material are being shared by the Kennedy Foundation and the Department. The National Association for Retarded Children is underwriting the costs of printing a pamphlet being distributed in conjunction with the campaign.

READERS' EXCHANGE

HROMADKA: *Training child care workers*

Van G. Hromadka's article deserves much attention. [“How Child Care Workers Are Trained in Europe,” CHILDREN, November–December 1964.] The training of child-care workers is an urgent matter.

The principles Mr. Hromadka expresses are excellent: (1) The need for respect for child-care workers and the establishment of equal status with other professionals; (2) the need for comprehensive training programs; (3) the treatment of the child as a child regardless of his handicap; (4) the equal treatment of residential care and care outside the residence. However, his contention that all this is available in Europe or at least in the countries he studied is a misleading generalization.

Certainly there are some places in Europe which have the kind of training Mr. Hromadka describes and where child-care workers are accepted as equals. Yet the status, even of professionals working in the child-care field, such as social workers and educators, is in many European countries so low that children in institutions suffer under practices which are the same as or worse than those found in many institutions here.

The fact that child-care workers receive 2 years of training says little about the quality of training. Many persons concerned with European institutions are painfully aware of their incredibly low standards, as we are of the low standards in some of our institutions in this country.

Perhaps it is not so important to discuss specific programs as it is to develop thinking about a realistic, possible and effective training for child-care workers. Mr. Hromadka's suggestion of a curriculum goes far beyond what is possible in a reasonable period of time, but it does give a basis from which to start. Actually, it reads like the curriculum offered to social group workers in American schools of social work, with some additions—a curriculum which requires in the United States at least 2 years of graduate study fol-

lowing 4 years of college. Can this be demanded realistically of all child-care workers?

Mr. Hromadka's call for a reassessment of child-care programs and the training of child-care workers must be heard, whether or not one agrees with all his facts.

Gisela Konopka

*Professor, School of Social Work,
University of Minnesota*

Author's reply

Dr. Konopka refers to my “misleading generalizations,” yet, to support her comments, she herself makes broad general statements. If I were to express my personal impressions gained overseas, I might agree with her that, from our concept of treatment, some European institutions would rate rather low, and that, on the whole, the social workers in this country enjoy a more thorough training and higher status than most of their European colleagues. However, neither the social work profession nor institutional treatment programs were subjects of my reporting.

I made it clear I was in no position to assess the qualitative results of the training discussed. My “contention” was simply to stimulate our own thinking about professionalization of child-care workers by sharing a few pieces of evidence that in some parts of Europe this idea has already taken a more definite shape.

It is erroneous to imply that I am suggesting “European” curriculum as a cure for our problems of training child-care staff. I am too well aware of the cultural implications involved to think that what may work in other countries must necessarily work here. Also, I do not believe that any sound new curriculum should be created without having first the facts about the actual and expected tasks of those to be trained and about the training presently provided. The human material to be trained is, of course, another phenomenon to be assessed.

In regard to the curriculum reading “like the curriculum offered to social group workers . . . with some addi-

tions,” it is these “additions” that I tried to point out and which I see important to take into account.

Van G. Hromadka

*Research Director, Professional
Child Care Project, Jewish Board
of Guardians, New York*

EISENBERG: *Author's reply*

Dr. Lauretta Bender and I differ less on questions of fact than we do on matters of philosophy. [See CHILDREN: “Role of Drugs in Treating Disturbed Children,” by Leon Eisenberg, September–October 1964; and “Reader's Exchange,” November–December 1964, p. 244.] When she states “drugs must always be a part of a treatment program, and one should know what kind of child is being treated with a specific medication,” I could not agree with her more heartily. But her disavowal of “treating children with placebos and blindly” seems to me to misconstrue the very nature of therapeutic research.

It is true that many important therapeutic contributions have been made on the basis of clinical observation and that subsequent controlled studies have done nothing more than to establish the validity of the original observation. However, the literature is also replete with examples of conclusions arrived at by uncontrolled clinical studies which proved to be incorrect both by the criteria of further clinical experience and by controlled trial.

As to toxicity, in our experience jaudie has followed the use of chlorpromazine in children, though rarely. The extrapyramidal syndromes can produce great distress in child and parents and can be all too easily confused with other medical conditions if the child comes to the attention of a physician not aware that the patient is under medication.

Dr. Bender has expressed a point of view which merits careful consideration. Whatever differences we may have about how to conduct therapeutic research, we would both agree that the skillful clinical management on the part of an experienced physician who adjusts his treatment program to the needs of the individual child is the best guarantee of the proper and effective use of drugs.

Leon Eisenberg, M.D.

*Professor of Child Psychiatry, The
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OME U.S. GOVERNMENT PUBLICATIONS OR PROFESSIONAL WORKERS

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IBLICATIONS OF THE CHILDREN'S BUREAU, Department of Health, Education, and Welfare, Welfare Administration, Children's Bureau, October 1964, 33 pp. Single copies available from the Bureau without charge.

This booklet lists all the Children's Bureau publications that are available for general distribution: those directed to parents, to teenagers, and to professional persons. Order blanks are included.

DALES, PROBLEMS, AND PROGRESS IN CHILD WELFARE: report of four regional meetings on implementation of the 1962 public welfare amendments. Department of Health, Education, and Welfare, Welfare Administration, Children's Bureau, Child Welfare Report No. 13, 1964, 90 pp. Single copies available from the Bureau without charge.

This report summarizes the content of four regional meetings of State child welfare directors called by the Children's Bureau between mid-November 1963 and late January 1964 to discuss

plans for implementing the new emphases for child welfare services identified in the 1962 amendments to the Social Security Act: extending services to all political subdivisions of the State by July 1, 1975; reaching all children in need of services; and expanding and improving day care services within the public child welfare program.

MAPLE SYRUP URINE DISEASE, HISTIDINEMIA. Two fact sheets on each disease, one for professionals, and one for laymen. Jane S. Lin-Fu, M.D., Department of Health, Education and Welfare, Welfare Administration, Children's Bureau, September 1964. Single copies free on request from the Bureau.

These fact sheets describe two diseases caused by inborn errors of metabolism. First described in 1954, untreated maple syrup urine disease (MSUD, maple sugar disease, or branched chain ketoaciduria) generally results in infant death or in severe mental retardation. Histidinemia, first described in 1961, usually results in a speech and language defect; it produces positive reactions to ferric chloride

tests of urine and so may be confused with phenylketonuria. The descriptions report encouraging results in treating MSUD babies with a synthetic diet, but no known specific treatment for histidinemia.

DAY CARE FOR OTHER PEOPLE'S CHILDREN IN YOUR HOME. Department of Health, Education, and Welfare, Welfare Administration, Children's Bureau, CB Publication No. 42, 1964, 17 pp., 15 cents.

This pamphlet offers suggestions to help day care mothers who do not have the help of social agency supervision.

DIRECTORY OF HOMEMAKER SERVICES, 1963; homemaker agencies in the United States. Department of Health, Education, and Welfare, Public Health Service, Division of Community Health Services, PHS Publication No. 928, 1964, 324 pp., \$1.50.

In bringing up to date a 1961 directory, this publication lists and describes the service policies of 303 agencies which administer homemaker programs in 41 States, the District of Columbia, and Puerto Rico.

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**CHILDREN AND YOUTH
AT THE MID-DECADE**

What are their opportunities and problems
5 years after the 1960
White House Conference
on Children and Youth?





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THE PLEASURE OF LEARNING, reflected in these school children's faces, is one of the potentials of children the 1960 White House Conference on Children and Youth sought to develop. The programs and issues involved in efforts to pro-

mote better health, welfare, and education for all children—discussed in this mid-decade issue of CHILDREN—have a great deal of bearing on whether children can find pleasure in learning or in any other aspect of growing up and living.

Dr. Edward Davens, a graduate of the Stanford University School of Medicine, is on the staff of the Johns Hopkins School of Hygiene and Public Health; chairman of the Committee on the Handicapped Child, American Academy of Pediatrics; and a member of the advisory committee to the Special Assistant to the President for Mental Retardation, a sequel to his membership on the President's Panel on Mental Retardation. He was formerly director of Maryland's maternal and child health and crippled children's programs.



During the 5 years he has been in his present position, Maurice O. Hunt has been making studies of State and local social services. Previously, he was director of child welfare for the State of Maryland, administrator of the Indiana State Department of Welfare, and before that director of the Indiana public assistance program. He has also been assistant director of the American Public Welfare Association. He received his social work training from the Indiana University School of Social Work.



Before going to the Pittsburgh school system in 1963, Sidney P. Marland, Jr., was superintendent of schools in Winnetka, Ill., and previously in Darien, Conn. He received his master's in education from the University of Connecticut and his Ph. D. from New York University. He is a member of the advisory committee of the Educational Policies Commission, and is on the visiting faculties of Northwestern University, Montana State University, and the National College of Education (Evanston, Ill.).



When Bertram M. Beck wrote his article, he was associate executive director of the National Association of Social Workers and executive director of the Academy of Certified Social Workers. He went to the Mobilization for Youth on March 1, 1965. A graduate of the School of Social Service Administration, University of Chicago, with experience in family counseling and work with delinquents, he was from 1950 to 1955 director of a special antidelinquency project for the Children's Bureau.



Marcia K. Freedman received her A.B. from the University of Michigan, her M.S. from the Columbia University School of Business, and her Ph. D. from the New York University School of Education. She was a staff associate for the 1960 White House Conference on Children and Youth; and then a research associate for the Youth and Work Project of the Taconic Foundation. She has been in her present position since 1962.



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LOOKING BACK AND AHEAD

KATHERINE B. OETTINGER

Chief, Children's Bureau



FIVE YEARS AGO this spring from March 27 to April 2, 1960, 7,600 people assembled in Washington from all parts of the country to participate in the Golden Anniversary White House Conference on Children and Youth, the largest of all the decennial White House Conferences on Children to be held since the first was called by President Theodore Roosevelt in 1909. Its purpose was "to promote opportunities for children and youth to realize their full potential for a creative life in freedom and dignity." In their deliberations, and through nearly 700 recommendations, the conferees made it clear that if these opportunities were to be achieved some major steps would have to be taken to improve services in the fields of health, welfare, education, employment, and juvenile delinquency prevention and control, and that not the least of these steps in relation to the elimination of racial discrimination in all areas of child life.

In the years since the Conference, many people have been working in local communities and on State and national levels to carry out its recommendations. At the same time, the accelerating pace of social change and some widespread social forces have affected many areas of child life. So that now, as we reach the halfway point in the decade, when our emphasis begins to shift from looking backward to the recommendations of the last White House Conference to looking forward to 1970, the significant problems facing children may not be the same as they were in 1960. For this reason, CHILDREN has asked five experts to present their impressions of what some of

the important changes are that have taken place in the fields given major attention by the Conference.

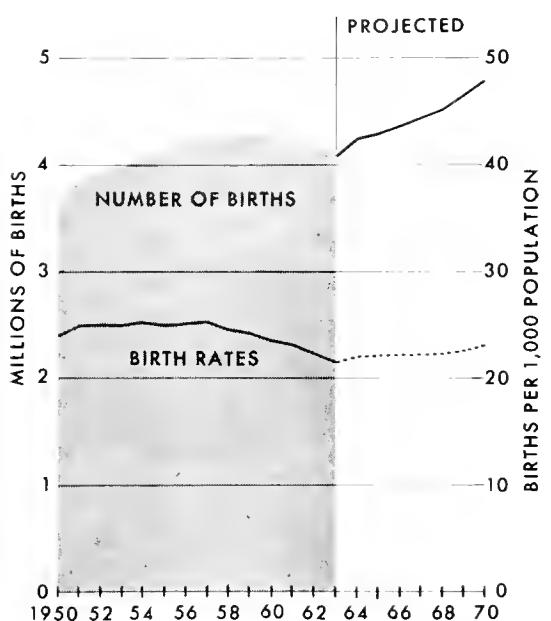
No one issue of a journal can, of course, give a complete picture of all that has occurred in these 5 years in even one of these fields, nor even of all that remains to be done. Highlights only can be presented as they are seen in each field from a single vantage point, the author's. And because they are presented from a national perspective, the reader must give his own interpretation as to what they mean to the children in his community; and then determine what he can do to give the extra push to eliminate the remaining, or new, stumbling blocks that lie in the way of children's achieving their potentials.

Social Forces

The problems of children occur in local communities and what is done about them must in the last analysis occur there too, but both problems and solutions are affected in no small degree by the economic and social forces that sweep over the Nation as a whole or through large segments of the Nation. Dramatic developments have occurred in the past 5 years, some of which hold threat and some promise for the welfare of children, and some the possible effects of which cannot now be seen. Many of these developments are referred to in the ensuing articles, but it seems important to underscore a few which are producing changes in the world of children and youth, even as this mid-decade issue of CHILDREN is being prepared.

1. The Population Explosion. As the total population in this country increases by leaps and bounds,

U.S. TRENDS IN BIRTHS AND BIRTH RATES



While both the number and rate of live births declined between 1960 and 1963, projections based on the rise in population of child-bearing age indicate a steady increase for the rest of the decade. Sources: National Center for Health Statistics and U.S. Bureau of the Census. (Series B projections.)

the total population of children is increasing even more rapidly. There are today 79.9 million children under 21 in this country as compared with 71.8 million at the time of the 1960 Conference. By 1970, according to Bureau of the Census projections, this number may increase to 85.7, an increase of 16 percent, or nearly 14 million children. At the same time, the number of elderly persons in the country is expected to increase by 17 percent, while adults in the most productive years of life, 25-64, may increase only half as rapidly (8 percent). Thus the responsibilities for the dependent portions of the population will be increasingly heavy on productive adults. The proportion of children to productive adults is expected to keep on increasing at least until 1980.

This poses not only food for thought but also a necessity for immediate planning for appropriate increases in all types of education, welfare, and health services needed by children, and for imaginative solutions to the problems of manning them with appropriately trained personnel.

2. Rising Expectations for Equality. One of the dramatic occurrences of the 1960 White House Con-

ference was the push given by the youth participants to the adoption of strong recommendations to end racial discrimination and segregation in all phases of life affecting young people. At that time the participation of college youth in lunch counter sit-ins was giving evidence of a growing commitment among serious-minded young people—especially Negro youth—to efforts to bring about equal opportunity for all. It is not necessary to enlarge here on the numerous events which have since given evidence of the snowballing nature of this commitment and its influence in bringing about a national commitment to the cause of equality of opportunity for all Americans now embodied in the Civil Rights Act of 1964. The impact on approaches to meeting the needs of children and youth should bring about rapid, profound and salutary changes in the lives of children, both white and nonwhite, in the months and years ahead.

3. Concern for the Poor. A perceptible change has taken place over the past 5 years in prevalent attitudes toward the poor. No longer need those who are concerned with raising the levels of living among the most disadvantaged portions of the population be on the defensive. Shocked into awareness of the grinding and binding effects of poverty by the appearance of a number of widely read books and reports on the subject, the Nation is taking a good look at its pockets of poverty and what makes them, and on national, State, and local levels, is devising measures intended to break the vicious cause-and-effect circle at many points. Many of these are described in the ensuing articles.

4. Technological Change. How successful the efforts to eliminate poverty will be may depend on great imponderable: Can the creation of new jobs keep pace with the job-bulldozing effects of industrial automation and agricultural mechanization?

The pace of automation has increased with progressive speed in the past 5 years, opening up vast opportunities for aspiring young scientists and technicians but threatening to create an increasingly stagnant pool of unemployment especially hazardous for youth. The unskilled are the most vulnerable; but what skills should young people be trained in that are insured against elimination by automation? Can training and the creation of jobs in the perpetually understaffed services move in to fill the opportunity vacuum? Or must there be a whole new look at possible approaches to maintaining and enlarging opportunities for youth?

These questions—discussed in more detail in other

of our articles—will undoubtedly still be of grave concern at the end of this decade.

5. Advancing Knowledge. The total amount of human knowledge has doubled in the past 15 years, according to a distinguished scientist. He is also reported to have said that we may very well drown, "not in our ignorance, but in our knowledge."

Much of the world's accumulation of knowledge directly concerns children—what they need for optimum development, what goes wrong and results in devastating handicaps, and what can be done to straighten a "bent twig," or at least to keep it from bending further. A tremendous increase in opportunities to secure support for research has stimulated a flood of inquiries into a variety of aspects of normal and abnormal growth and development and into methods of helping children to learn, grow, and thrive as healthy individuals. In the past 5 years, to give only a few examples, we have learned much about some of the causes of mental retardation, and about some of the sensory distortions that handicap children, and we have found ways of either preventing the initial damage or of halting further damage.

We will not drown in such knowledge, but there is danger that the promise and hope of many children may drown unless there is equal enthusiasm for bringing about more widespread application of what we already know and in many instances have known for many years.

6. Federal Legislation. The vast amount of Federal legislation in the fields of health, welfare, and education passed since the 1960 Conference—much of it, perhaps, at least an indirect result of the Conference—provides many pathways for reaching the Conference's goals. Some of the most influential measures in shaping the course of community efforts now and in future years are mentioned in the ensuing articles. Altogether, Congress has enacted more than 40 significant laws directly connected with health, welfare, and education since 1960. These laws extend and improve existing Federal or federally aided programs, provide greater support for state services, and encourage concerted approaches of all appropriate resources within communities to identify human or institutional malfunctioning and to make efforts for eliminating or modifying it.

The President's recent State of the Union message and health and educational messages, which were followed almost immediately by bills to increase the health and educational opportunities for children, indicate that this trend of strengthening and extend-

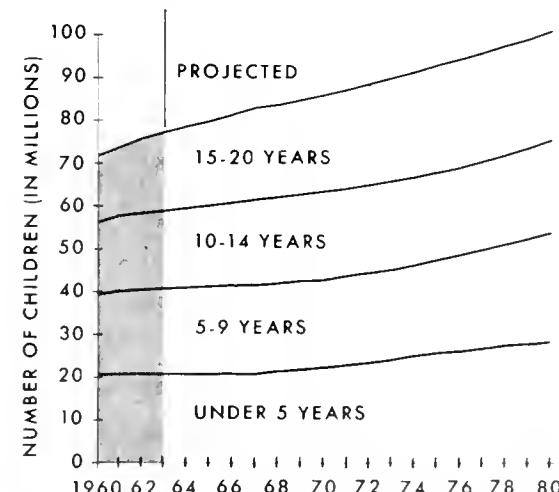
ing the Federal undergirding of efforts to promote the general well-being of families and children may continue as we move toward 1970.

7. WHC Followup. Surely not the least effective in the many forces for change in the past 5 years have been the activities of thousands of persons across the country who have been working to achieve the recommendations of the 1960 Conference through the mechanisms created for Conference followup.

The National Committee for Children and Youth, created by the Conference Executive Committee to stimulate followup activities, was also charged with the responsibility of reporting on these activities 5 years after the Conference. Its report is now being prepared on the basis of 167 questionnaires sent to the member agencies of its constituent organizations, the Council of National Organizations for Children and Youth, the National Council of State Committees for Children and Youth, and the Interdepartmental Committee on Children and Youth.

Not all the responses are in at this writing, but those that are give an indication of a great deal of activity in States and communities in line with the Conference's emphases on the health, welfare, and educational needs of children, and its concern over juvenile delinquency, dwindling employment opportunities, and racial discrimination. No brief summary can give an indication of the many young people and adults involved in this activity in national conferences, State conferences, community confer-

PROJECTED GROWTH IN U.S. CHILD POPULATION



Source: U.S. Bureau of the Census (Series B projections).

ences, legislative lobbying, studies, surveys, projects.

The National Committee for Children and Youth has provided stimulation by producing publications on a variety of topics; by joining with its constituent organizations in sponsoring two biennial Joint Conferences on Children and Youth, one focused on youth's participation in community affairs, and the other on ways of translating new concepts into services for children and youth; by initiating a project to bring rehabilitative services to youth rejected as Army volunteers; and by sponsoring two special conferences which have played no small part in calling national attention to the plight of unemployed youth—the Conference on Unemployed Out-of-School Youth in Urban Areas, held in Washington, D.C., in 1961, and the National Conference on Problems of Rural Youth in a Changing Environment, held in Stillwater, Okla., in 1963.

The Interdepartmental Committee on Children and Youth, also taking its cue from the 1960 Conference recommendations, has produced proposals through its subcommittees for getting rehabilitative health services to Selective Service rejectees; for helping young people in the transition from school to work; and for drawing on the potentials of youth to provide constructive services. These have already been incorporated into national programs.

Forty-seven States and territories have committees for children and youth, some appointed by the Governors in preparation for the 1960 Conference and some dating back to the 1950 Conference. These have worked, following the Conference, with varying degrees of intensity to bring about the community involvement upon which any lasting improvement in the conditions affecting children depends. A report on these committees, based on a study by the Children's Bureau, is now in preparation.

The Children's Bureau has, of course, had a pervasive part in White House Conference followup. Its programs by their very nature are committed to the Conference's objectives. It has also carried out some direct followup activities through the preparation of special publications, the provision of consultative services to State committees (representa-

tives of 42 State committees for children and youth were visited by a staff consultant last year), and through the provision of staff services to the Interdepartmental Committee on Children and Youth which is representative of 37 Federal agencies.

Looking Toward 1970

As the population increases and the pressures of modern life produce a growing tendency toward depersonalization in our society, those of us who are working in behalf of children know that there will be increasing demands on our services. We also know that the critical challenge today is to stop the waste in human resources by finding ways of substituting modern practices for those which in the light of present knowledge are anachronisms.

The following articles describe the ways some of the major obstacles which block children's opportunities have been attacked since 1960, some shift in perspective and direction, some resetting of priorities for the future. They point to many accomplishments, and from these we can take heart. They also make clear that many obstacles remain, not new perhaps in some respects even smaller, but nevertheless large and resistant for many, many children.

We cannot hope to eliminate all of these obstacles by 1970, or even perhaps by the year 2000. But we can continue to hack at them with all our strength, continually honing our tools, and being vigilant for new obstacles which may appear like Gorgon's head when one has been cut down.

In historical perspective, 5 years are less than second; in today's fast-moving world they can bring dramatic and unforeseen changes; in a young person's life they can mean the unfolding or destruction of potentials. We cannot tell what all the problems demanding attention from 1970 conferees will be. We do know that many of them are with us now and that the needs of children will remain the same for love, understanding, encouragement, and guidance; and for opportunities to increase their knowledge about the world they live in, to learn useful skills, to test their abilities, to enjoy self-fulfillment and to find ways of participating in community life.

. . . there is a considerable gap between observing a need and knowing how it can in practice be met.

"Youth Problems: Poverty and Social Action Programs," in *The First Five Years, 1958-1963, Syracuse University Youth Development Center, Syracuse, N.Y., 1964.*

A VIEW OF HEALTH SERVICES FOR MOTHERS AND CHILDREN

EDWARD DAVENS, M.D.

Deputy Commissioner

Maryland State Department of Health

MORE THAN 100 of the 670 recommendations of the 1960 White House Conference on Children and Youth directly involved the health and medical care of mothers and children. In reviewing these, one is reminded of the French proverb *plus ça change, plus c'est la même chose*. At the beginning of the Great Depression, the 1930 White House Conference on Child Health and Protection issued a ringing Children's Charter proclaiming the right of all expectant mothers to good comprehensive maternity care and the right of all newborn infants to continuous medical health supervision. Yet, 30 years later, in 1960, in the midst of the greatest period of affluence any nation has ever known, another White House Conference still found it essential to make these two basic recommendations:¹

That pregnant women be provided with good obstetrical care and protected from infections, excessive radiation, certain drugs, dietary deficiencies, and any other conditions which may damage the fetus or cause premature birth and possible mental retardation. . . . [393]

That periodic examination and continuous medical and dental care, including vision, hearing, and lingual problems, early detection and treatment of defects and abnormalities, as well as the prevention and early treatment of disease, be provided for all children. . . . [388]

Now that we are midway between the 1960 and 1970 White House Conferences on Children and Youth, it is well to look at some of the major health problems facing children and mothers today, to review the progress of the past 5 years, and to venture a few guesses about future directions. Such a review in so small a space cannot, of course, be comprehensive. Therefore, the points made must be selections based on the experience and preference of

the author. Readers who are disappointed by omissions or who wish further information can examine the publications noted in the references.

Maternal and Infant Mortality

In terms of survival, mothers and children of the sixties have far less chance of dying than their predecessors of the past 50 years. Pregnancy today is only one-seventeenth as risky to the mother's life as it was in 1915. Though at the time of the 1960 Conference this trend was showing signs of leveling off, it has since continued downward.

Infants born today in the United States have at least four times the chance to celebrate their first birthday as they did in 1915. Satisfaction in this accomplishment is considerably tempered by the facts that the downward trend of infant mortality in this country has nearly leveled off since 1950 and an increasing number of countries have been experiencing lower infant mortality rates than the United States. (Australia, Canada, Denmark, England and Wales, Finland, the Netherlands, New Zealand, Norway, Sweden, and Switzerland.) Also, the gap between the rate for the United States and the figures for countries with the most favorable experience has widened. Shapiro and Moriyama, who have pointed to the conspicuous lag in reducing the infant mortality rate in the United States, conclude:

The fact that there are other countries with much lower loss rates suggests that even without a major breakthrough in medical knowledge, a rapid reduction in infant mortality rates in the United States from the present level of 25-26 per 1,000 to a point below 20 per 1,000 is a realistic goal.²

One deterrent to maternal and child health which is basically a psychological phenomenon of many

years' duration is the fact that America simply does not take pregnancy, labor, and delivery seriously enough. Barnes has pointed this up:

In hospital practice the removal of a brain tumor calls for a surgeon with two assistants, a scrub nurse and two circulating nurses, an anesthetist and an assistant. The patient's prognosis is about 18 months and the hospital investment is tremendous. The birth of a new baby at 4 a.m. more often is attended by one physician, no scrub nurse, one circulating nurse, and inadequate or haphazard anesthesia coverage. The combined prognosis of the two patients is over a hundred years, but the hospital investment is minimal.³

After the delivery, the newborn infant, who then carries a far greater mortality risk than on any subsequent birthday until his 70th, is not even counted as a hospital patient. Moreover, because of increasing pressure on limited maternity facilities in hospitals, and for economic reasons, the average length of stay for newborn infants, especially those from low-income families, who are at greatest risk, has dropped precipitously. A stay of 48 hours or less for a newborn infant and his mother is not unusual.

Granted that the desirable length of hospital stay for newborn infants is debatable, strictly economic considerations should not be the primary determinant when we are dealing with patients in such a critical stage in their development and when so many opportunities to prevent unwanted developments are present in the hospital.

Prevention of major handicaps is based on early recognition of defects. The hospital maternity ward and nursery for newborns are ideal settings for a prevention laboratory. Since about 99 percent of all newborn infants are born in hospitals, the maternity wards present a golden opportunity to assess maternal capacity for child rearing and, in the process, to identify high-risk mothers and to transmit their records automatically to persons responsible for continuing health supervision of the infant. The newborn nursery offers the chance to recognize high-risk infants during the first few days of life⁴ by routine and systematic application of selected screening criteria, and to record information about them.

Other procedures which can and should be applied in the hospital would include: giving each newborn an examination for those congenital malformations which are recognizable at birth, a neurological examination, and a screening test for inborn metabolic errors such as phenylketonuria; testing prematures for serum bilirubin (a test for jaundice); and carrying out a planned program of health education of the mother, with emphasis on the importance, nature, and

sources of continued health supervision of her child.

In order to accomplish such an organized exercise in prevention, the hospital stay for mother and newborn infant would have to be lengthened to a minimum of 3 days, preferably 4. Is this impossible?

It should not be, but in many of our large cities which contain the most advanced medical facilities in the world—lengthening the hospital stay of maternity patients poses a knotty problem of hospital bed distribution. Technical advances, along with inflation, have boosted hospital costs to astronomical proportions in recent years. At the same time, the cities' sources of revenue have dwindled as the high-income portions of their populations have moved to the suburbs; and the burden of health care which must be borne by the cities has become increasingly heavy, the vacuum left by the departure of the well-to-do has been filled by the poor and dispossessed. Since many cities can no longer afford to purchase care from the large well-equipped voluntary hospitals in the midst, care of the indigent becomes concentrated in large, overcrowded, understaffed municipal hospitals where rapid bed turnover is a necessity because of the pressure of incoming patients. In some city hospitals, maternity patients with no obvious medical complications are released 24 hours after delivery.

Poverty

In an excellent recent review of maternal and child health problems, Yankauer⁵ discusses the increasing disadvantage during recent years of Negro infants as compared with white infants, as measured by maternal and infant mortality. At the same time, the proportion of total births which are nonwhite has increased. According to Yankauer, the greatest evidence of a growing disparity in advantages between whites and nonwhites lies in maternal and postneonatal death rates. In 1962, these rates for nonwhites were four and three times as high as the respective rates for whites. Forty years previously, the rates for the two groups were far higher in absolute terms but much closer to each other in relative terms.

Certainly this disparity does not reflect only the effects of racial discrimination in the provision of health care. In all probability, economic, educational, and occupational differentials are more important factors. However, relatively few studies have been made relating maternal and infant mortality to these determinants of social class. Those which have been carried out show a clear inverse relationship between family income and infant mortality. The same relationship has been shown using time

ther's occupation as an indicator of social class.

In 1962 the report of the President's Panel on Mental Retardation⁶ emphasized the vital importance of social and cultural deprivation, as manifested in the slums of our large cities, as a hazard to maternal and child health and to optimum growth and development of children. In the Economic Opportunity Act of 1964, Congress clearly recognized the environmental factors which both result from and perpetuate poverty and provided for a multipronged attack against them.

An area of Baltimore for which an antipoverty plan has been devised provides a typical picture of the intertwined, interacting characteristics of the slums in many of our large cities.⁷ The area, as described in the plan of action, has considerably higher rates of infant mortality, juvenile delinquency, tuberculosis, adult crime, male unemployment, and dependency on public aid than the city as a whole. Over 40 percent of its 46,000 families have incomes of less than \$3,000 per year. Of its 15,000 persons over 25 years of age, more than half have had less than 8 years of education; over 9,000 are unemployed. Over 45 percent of its 64,000 housing units are considered not sound. The plan proposes a new agency to synchronize and expedite the delivery of remedial education, employment, health, social, and related services to the low-income population. A comprehensive maternity and infant care program is one of its 24 program proposals.

The relationship of poverty and its many underlying causes to poor maternal and child health has been well established for many years. But only recently has this concept of a multidisciplined, multigenic, multifaceted attack on the results and causes of poverty received attention. Now as the accepted concept in the war on poverty, it becomes the greatest challenge and opportunity for improving maternal and child health in 1965.

Maternity Care

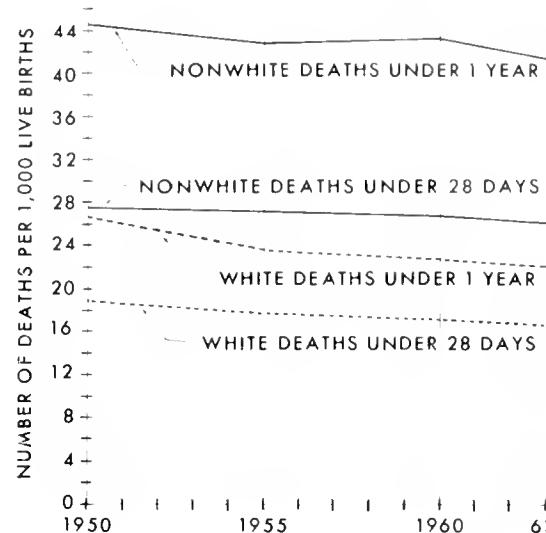
Since the 1960 White House Conference, there has been a continuing dialogue about the degree to which the failure of many women to receive modern scientific maternity care is due to shortcomings in the adequacy of services and the degree to which it is due to lack of acceptance of opportunities for care by cultures within our population.

Let us simply agree that the truth lies somewhere between and proceed at once to improve "adequacy" and increase "acceptance."

A comprehensive view of how far we have to go

INFANT MORTALITY TRENDS IN THE UNITED STATES

White and Nonwhite, 1950-1963



The trend lines in this chart speak for themselves. Their statistical sources are the National Center for Health Statistics, and the Children's Bureau, Division of Research.

can be obtained from the proceedings of an institute on maternity care held at the University of California in June 1964, under the auspices of the Children's Bureau.⁸ The volume also provides an excellent guide for taking vigorous steps ahead.

In the municipal hospitals of our large cities, where the obstetric patients are of low-income status, nearly one-half of the maternity cases receive prenatal care only late in pregnancy or not at all. The lack of care is greatest among young primigravidae, who are often unwed, and among the grand multiparas, who have little time for, or interest in, concerning themselves with the new pregnancy. How to reach these women early in pregnancy and how to provide them with continuity in care are pressing problems because these are the women most subject to special hazards in pregnancy.⁹

Part of the problem of obstetric care as available for low-income families today lies in the dissatisfaction of patients with the long waiting hours and impersonal attitudes encountered in the clinics. As with inpatient hospital facilities, the outpatient clinics of many municipal hospitals are faced with great overcrowding and understaffing, which make it impossible to give adequate care. Moreover, the problem is increasing. These conditions discourage women heavily burdened with other problems from seeking or following through with prenatal care. Yet



Gentle doctor, concentrating mother, and just barely cooperating baby as they participate in a well-child conference.

the importance of prenatal care to primary prevention of defect in the infant is well established.⁸

We live in a country where marketing research and methods have long been applied to distributing goods and services in easily available fashion, close to where people live, and in attractive ways which appeal to and are acceptable to special groups. Is it possible that in designing the distribution of maternity services we could learn from industry and take into consideration the importance of making them attractive and convenient for the client as well as improving their intrinsic quality?

A real milestone on the road to improvement was reached on October 24, 1963, the day that President Kennedy signed into law the Maternal and Child Health and Mental Retardation Planning Amendments of 1963 (P.L. 88-156).¹⁰ Among other things, this law provides funds to the Children's Bureau to initiate and develop comprehensive maternity and infant care projects to help reduce the incidence of mental retardation. These projects, which provide for continuity of prenatal, parturitive, and postpartum care, are now beginning to get under way, especially in the slums of our large cities.

Not one of the 670 recommendations made by the 1960 White House Conference on Children and Youth dealt directly with family planning services as a key component of a maternal and child health

program. Now, 5 years later, it is generally recognized by public health authorities throughout the world that population control and family planning services constitute a public health problem of top priority. The major opening session of the 1964 annual meeting of the American Public Health Association was devoted to discussion of various aspects of population control. Universities are developing institutes for scientific research in all aspects of population control and for training of personnel, for both research and service. Progress is being made in number of States and in the District of Columbia in developing family planning services based on a methods of birth control, including the rhythm method, as an integral part of local public health services.¹¹ In some areas, Federal aid for such services is being obtained under the community action provisions of the Economic Opportunity Act.

Maternal and child health history may well show that this long-delayed recognition of the social and individual hazards in uncontrolled reproduction may be the most significant of all recent developments in improving the health of mothers and children.

Out-of-Wedlock Births

From the handicap-prevention and development points of view, births out of wedlock continue to be primary problem since they represent nearly 6 percent (about 250,000 babies) of our annual live birth.

Reported births out of wedlock are more prevalent in the lower socioeconomic segments of the population, but are by no means limited to these groups. Their association with low incomes is undoubtedly an important factor in their greater frequency among Negroes, who have a much higher proportion of the population on the lowest rungs of the income ladder. Some cultural factors and the greater availability of higher income groups of means to prevent or keep secret unwanted pregnancies may also be factors.¹²

The dangers for the child of the mother's unmarried status are indicated by a study carried out in New York City which showed that pregnancy in unmarried women is more likely than in married women to terminate in premature birth or late fetal death.¹³ Other studies have shown a high association of prematurity with birth defects and infant death. It follows as simple logic that unmarried mothers and infants born out of wedlock are high medical risks which must be given a high priority in maternal and child health programs.

Many persons contend that unmarried motherhood is increasing; and, indeed, the numbers of women

reported as giving birth out of wedlock have gone up with the increase in population of women of childbearing age, usually considered as ages 14 to 44. However, the rate of births out of wedlock among women in this age group has remained about the same since 1960.

About 40 percent of the unmarried women who bear children out of wedlock are below the age of 20, although 68 percent of all unmarried women of childbearing age are under 20.¹² While this indicates that the problem of unmarried motherhood is less prevalent among unmarried teenagers than among older unmarried women, it still represents a sizeable group whose problem is complicated by the special physical and psychological hazards to both mother and child presented by the mother's immaturity.

Day-Care Opportunities

Children who are left to fend for themselves or who are provided with inadequate supervision, stimulation, and care face grave risks to their health, physical safety, and emotional development. In recognition of this fact, the 1960 White House Conference urged government aid to increase the number and quality of day-care services and their staff.¹³ (Recommendation 351.) In 1962, Congress authorized a special program to help the States set up or encourage such services and in 1963 appropriated funds specifically for this purpose. Since then, 49 states or other United States jurisdictions have made plans to strengthen and expand day-care services within their States. However, by and large, progress in this critical area has been disappointing. A far greater expansion of facilities than has thus far taken place is essential. Increasing numbers of children of working mothers need arrangements for daytime supervision and care, as do numerous children from disadvantaged families whose parents are similarly incapable of providing them with the kind of care, supervision, and stimulation young children need for normal development.

A growing awareness that many children in the home do not receive the kind of care and early reciprocal communication with adults that are necessary for normal development has prompted a number of experiments to determine whether group day care can be provided for children under 3 without detriment to their emotional development. The use of licensed family day-care homes is also being suggested to meet these children's needs, but so far this type of service, where available, is generally limited to children of working mothers.

The Economic Opportunity Act of 1964 has the tremendous potential for supplying some real forward motion for the children in greatest need of day care services or in need of preschool education. If we are to save a sizeable segment of the Nation's most valuable resource—our children—from developmental erosion, we had better get on with the job of applying some of the scientific research in which we take such pride. Hopefully, we will see some rapid, bold, and heuristic developments in upgrading the environmental stimulation in the early years of childhood as the community action programs in the war on poverty get under way.

Adolescent Medicine

By 1970, the adolescent population of this country will be 10 percent larger than it is today. While medical interest in the special problems of adolescents is not growing nearly rapidly enough, it has picked up speed since the last White House Conference. Of 230 hospitals about which information was obtained in a recent survey, 60 operated special facilities for adolescents—10 adolescent wards, and 34 adolescent clinics. Of these 34 clinics, only 9 were reported to be in operation in 1960.¹⁴

In order to develop professional understanding of the health problems of adolescents, the Children's Bureau has begun supporting five training centers in adolescent medicine in medical schools. As the adolescent population rises, it becomes more and more important that all physicians in training have a sound understanding of the special emotional and physical aspects of this stage of growth and development.

Mental Retardation

Perhaps the greatest milestone for child health in the past 5 years was the report of the President's Panel on Mental Retardation in October 1962.¹⁵ The very broad approach taken in its more than 90 major recommendations provides an excellent handle to the solution of other fundamental problems of child health and welfare. President Kennedy signed two major pieces of legislation to implement many of these recommendations: (1) the already mentioned Maternal and Child Health and Mental Retardation Planning Amendments to the Social Security Act, which add new dimensions to maternal and child health and crippled children's services, as well as providing Federal support for State planning to prevent and ameliorate retardation; and (2) the Mental Retardation Facilities and Community Mental Health Centers Construction Act of 1963 (P.L.

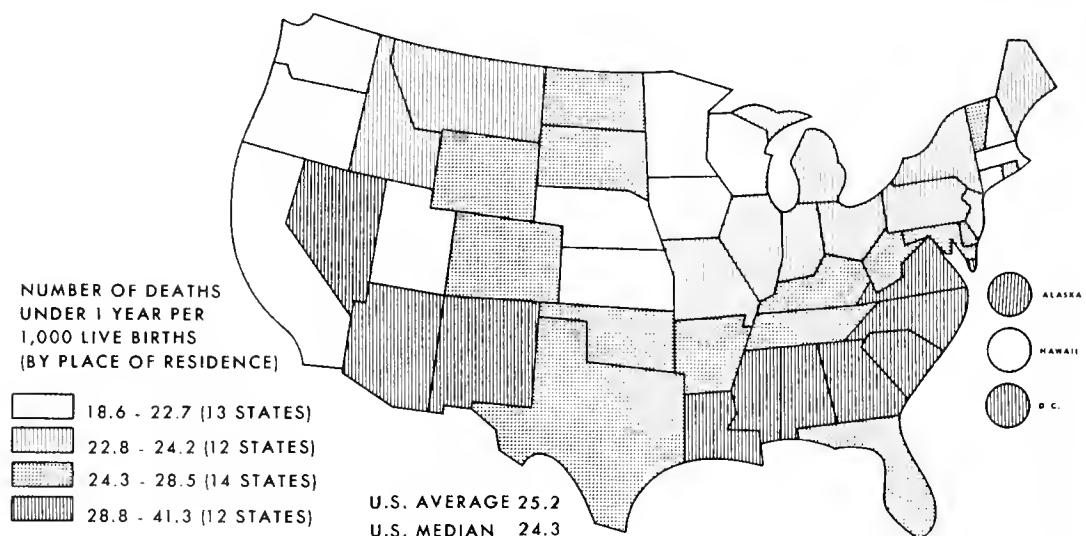
88-164), of which more will be said. Progress along many fronts—basic research, preventive health measures, diagnosis and treatment, education, and vocational training—is described in publications of the Department of Health, Education, and Welfare.¹⁵

The growth of clinics for mentally retarded children is one of the dramatic developments of the past few years. At the time of the 1960 White House Conference, there were 73 such clinics. A few of these clinics date back to the late forties, but a few years before the Conference, in the late fifties, the Children's Bureau established a program which has had a tremendous influence on their spread. The number has steadily increased until now there are 128 clinical programs for mentally retarded children in this country; and more are being planned. In most of these programs, the clinical team includes a pediatrician, who is usually the medical director, a psychologist, a medical or psychiatric social worker, and public health nurses; and, in some clinics, also a child development specialist, a speech therapist, and a nutritionist. Other medical and nonmedical specialists are called upon when needed, since every attempt is made to treat the whole child. In fact, the focus in an increasing number of these clinics is so broad as to make them almost indistinguishable from the more recently developed clinics for the multiply handicapped, which include the retarded.

In the past 5 years, there has also been growing recognition of the importance of increasing the skills of professional persons who work with retarded children, a point stressed in the report of the President's Panel on Mental Retardation in October 1962.⁶ Some of the clinics have this focus. Further steps to meet this need for training and the need for more research related to retardation—as well as the need for greater availability of services for retarded children and adults—are receiving great impetus from the Mental Retardation Facilities and Community Mental Health Centers Construction Act of 1963. Among its provisions concerned with retardation, this law authorizes \$22,500,000 for the construction of "university affiliated centers" to provide a "full range of inpatient and outpatient services for the retarded and to be associated with university hospitals or other parts of universities.

In addition to operating a variety of programs inpatient and outpatient diagnosis and treatment, laboratory work, day-care centers, demonstration schools—these centers will probably affiliate with a number of already existing community facilities such as public school special classes, sheltered workshops, vocational training classes, and residences for long-term care. They are expected to involve all the appropriate departments or schools of the universities which can play a role—medical, dental, social work,

INFANT MORTALITY RATES IN THE UNITED STATES, 1963



The map shows where the greatest problems in infant mortality are. Source of data: National Center for Health Statistics.

ursing, psychology, sociology, education, and public health, for example.

Their inpatient facilities will be part of a pediatric teaching unit or immediately adjacent to it. Thus, cases requiring detailed observation can be admitted for initial diagnosis and evaluation. Other cases can be admitted for clinical research, for demonstrating to physicians particular kinds of clinical problems in mental retardation, or for demonstration purposes in the training of nurses, social workers, and other personnel.

Thus, the centers will have a tremendous potential for carrying on high quality training and research. They will offer opportunity for longitudinal observation of children with retardation and other cerebral dysfunction; experience with the wide array of services and facilities such children need at different ages of their life cycle; and a working acquaintance and understanding of the roles of the various professions involved in their care.

Pertinent to the work of these centers, and to other services for retarded children, will be developments under another provision of the act which authorizes \$20 million for the construction of facilities for research in human development, "whether biological, medical, social, or behavioral."

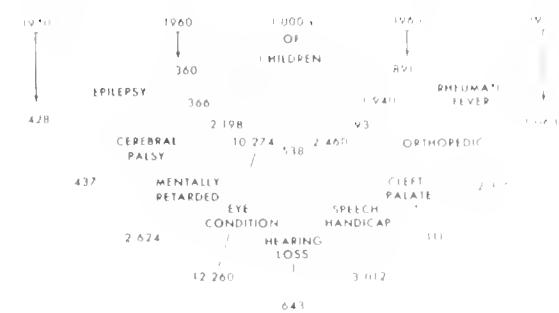
The act also brings families of retarded persons promise of greater access to services by authorizing a total of \$67,500,000 for the construction of facilities for services to be open to persons unable to pay, the location and type to be based on State inventories of existing services and surveys of need.

Handicapped Children

Two encouraging trends which began well before the 1960 White House Conference have continued in an accelerated pace in recent years: (1) the tendency for State crippled children's programs to broaden their definition of a handicapped child to include an increasing variety of conditions; and (2) a tendency to drop illogical and untenable restrictions from these programs, such as those preventing a physically handicapped child who also has mental retardation from receiving treatment. The acceleration of these changes probably has several sources. One of the task Forces of the President's Panel on Mental Retardation focused attention on the plight of the physically and mentally handicapped child;¹⁶ and subsequent legislation increased Federal funds for crippled children's services so that liberalization of State policies became feasible.

A part has also been played by the crystallization

HANDICAPPING CONDITIONS AMONG CHILDREN



The most prevalent conditions handicapping children at the time of the last White House Conference on Children and Youth and estimates of their probable incidence in 1970.

of medical concepts that disease states are the indirect outcome of a constellation of circumstances rather than the direct result of a single determining factor. Indeed, the Report of the President's Panel on Mental Retardation⁶ reflected the increasingly accepted idea that the social and psychological, as well as physical, characteristics of the total environment, affect the disease patterns of the community. During the next 5 years, there are likely to be further trends toward broadening the definition of handicapped children and toward the organization of services and facilities to permit an integrated approach to the whole child, regardless of the number, type, or combination of handicaps he presents.

A relatively new development along these lines has been the establishment of interprofessional clinics for the diagnosis and evaluation of children with multiple handicaps, especially neurological and sensory handicaps, frequently including mental retardation. These clinics are staffed with a variety of medical disciplines in addition to the professional representation found in clinics for the mentally retarded. A single person, usually the pediatrician in charge, provides the essential continuity of care and counseling to the child and his family.¹⁷

In some of these centers, collaborative biomedical-educational research is developing improvements in the techniques of special education, to relate them more precisely to the problems of disordered structure, chemistry, and function in the individual.

In such clinics, all the pertinent data about a child are integrated into a working diagnosis and plan of habilitation usually by means of a case conference at which all of the specialists are represented. One of the important benefits of this organization of serv-

ices around the whole child is in the quality of training of future physicians and members of other health professions. It affords understanding of other disciplines' skills, facilitates working together, and increases awareness of the variety of community resources needed by the handicapped child.

There remains, however, a long-standing and distressing gap in services and facilities for the handicapped. Little or no progress has been made in meeting the rather special needs, especially for long-term residential care, of the child who is *both* blind and deaf, or mentally retarded, blind, and deaf; the young adult with very severe cerebral palsy but normal mentality; or the young person with paraplegia or quadriplegia—one of an increasing number—who is not capable of achieving independent living. This gap needs immediate attention.

A Change in Vision

Space limitations have allowed mention here of only a few of the specific problems and advances which have marked the past 5 years' progress toward the goal of adequate conditions and services for helping children reach their greatest potential for physical and emotional health. Above all has been a widespread change in vision and determination.

This was wrought by the leadership of our amazing young President, John F. Kennedy, whose meteoric thousand days established the pursuit of excellence as a national way of life. Through his wide reading and frequent contacts with scientists, he understood that in an age in which it is possible to split the atom and voyage to the moon it is also possible—and just as important—to improve the quality of human reproduction and development. He demonstrated this vision by his appointment of a Task Force on Health and Welfare even before his inauguration, and acting on one of its recommendations within the first 90 days of his term by creating the new National Institute of Child Health and Human Development.

President Kennedy was well aware that the health problems of mothers and children are extremely complex, massive, embedded in our society, and amenable to no simple solutions. But he said: "*Let us begin;*" and we did. In his charge to his Panel on Mental Retardation, he said that the quality of a civilization can best be judged by the way in which it treats its less fortunate citizens. A great amount of "forward motion"—to use his phrase—is now

under way in improving the quality of our American civilization.

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PROGRESS AND ISSUES IN CHILD WELFARE SERVICES

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THE YEARS since the 1960 White House Conference on Children and Youth have been crucially important in the social welfare field. Paradoxically, the most significant developments for the welfare of children have occurred outside the sphere of "social welfare" itself. These are the greatly accelerated moves toward realization of civil rights for Negroes, and the emergence of a national commitment to end poverty. In the light of these developments, the theme of the last Conference—"to promote opportunities for children and youth to realize their full potential for a creative life in freedom and dignity"—was prophetic, perhaps even beyond the dreams of those who framed it.

The 1962 Public Welfare Amendments to the Social Security Act¹ have also done much to point the way toward realization of the goals for children expressed in the Conference theme. In this legislation, Congress clearly expressed its intention that public assistance applicants and recipients should be provided with necessary social services as well as with financial assistance. The way was thus opened for a nationwide effort to provide better protection and expanded opportunities for children in the Federal-State program of aid to families with dependent children.

In these amendments, Congress also broadened and made more specific the definition of child welfare services for which the States could expend Federal funds. Even more important, Congress expressed its desire that all States have comprehensive child welfare services available by 1975 for all those children who need them. As a part of this broad new approach, Congress also emphasized a national interest in the provision of proper day care for children, and—through the Maternal and Child Health and Mental Retardation Planning Amendments of 1963—special efforts on behalf of the mentally retarded.²

In each instance, congressional commitments were supported by the establishment of special programs and by appropriations to implement new services. Some of these programs are already in operation. All of them are too new at this point for full evaluation. What is important to recognize, however, is that each represents a clear commitment on behalf of the American people to carry out specific goals related to the welfare of children—all necessary for moving this country in the direction of equal opportunities for all children.

There are, of course, wide gaps between these stated goals and their achievement. In some instances, important progress has already been made. In regard to others, the programs and the resources being made available fall far short of what is needed. These national commitments and the beginning programs which back them up do, however, open the way for a different approach to the welfare of children from that which was possible 5 years ago.

Against Poverty

Poverty is a certain and a cruel enemy of children. It deprives them of wholesome food in sufficient amounts to grow up well and strong. It results in neglected teeth and untreated health problems. It sends children to school ashamed of their clothing and unable to participate in activities which may be essential to their proper social development. It forces children to live in unsuitable houses and bad neighborhoods. It pushes them out of school and into dead-end jobs long before they are prepared to enter the complicated kinds of employment for which they are going to be needed in this age.

The protection of children from poverty has been one of the major preoccupations of social welfare for many years. These efforts were greatly accelerated

by the passage of the Social Security Act in 1935, which provided the Nation with new and improved tools in the public programs of financial assistance, insurance against certain hazards, and social services. In spite of these efforts, however, large numbers of children in this country are today living in poverty. In a recent article,³ Helen Witmer estimates that in 1961 one-fourth of all American children were growing up in families whose incomes were clearly inadequate to meet their basic needs. Furthermore, of the 17 million children living in families falling below the poverty line, 3 million were living in families whose incomes were less than \$1,000 per year. Clearly, new approaches to the problem are urgent.

Some new approaches will be possible under the Economic Opportunity Act of 1964.⁴ If, for example, older teenagers can become self-supporting or learn job skills which will enable them to increase their earnings, the poverty pressures upon their younger brothers and sisters will be lightened. Also, retraining opportunities should open the way for unemployed parents to find jobs and for others to upgrade their earning power. The specialized programs for migrants authorized under the act should be useful in mitigating some of the ravages of poverty on children in these families. Moreover, some of the many experimental community programs which are being developed under this act may point the way for a broad attack against the links in poverty's circular chain of cause and effect, in which the poor are often bound for generations. Taken as a statement of national determination, the Economic Opportunity Act brings hope that over the next few years steps will be taken which will go far to protect children of the future from the terrible ravages of poverty.

Public Assistance

In the meantime, however, nothing in these new efforts negates the importance of providing adequate financial assistance for needy children and their families today. Forum after forum in the White House Conference of 1960 pointed out serious deficiencies in the financial assistance programs of this country, and called for increases in assistance grants to enable children to live in accordance with standards of decency and health.⁵ (Recommendations 370 to 377.) Here, unfortunately, comparatively little progress has been made during the last 5 years.

In November 1964, each child and adult recipient in the AFDC program averaged \$33.20 in assistance for the month, including payments for medical care. On the basis of a 1961 nationwide study of families

receiving AFDC, Kahn and Perkins recently reported that: "Of the 35 million impoverished Americans included in President Johnson's 'one-fifth of the Nation' estimate, the 4 million adults and children who receive aid to families with dependent children (AFDC) are among the poorest."⁶ In that year the total annual income from all sources of families in the program averaged \$1,680. In no State was the total average income as much as \$2,400 per year and in one State it was barely over \$750. This study excluded vendor payments for medical care made behalf of the recipients. In late 1961, such payments averaged \$100 per family annually.

Although no similarly intensive study has been done since 1961, the authors conclude, on the basis of partial data, that "the financial circumstances of AFDC families have changed little since 1961 and that the conclusions drawn from the 1961 survey continue to be valid."

Needy children whose families are not eligible for AFDC are in an even more serious plight. In numerous studies throughout the country, the National Study Service, a community research agency sponsored by the Child Welfare League of America, Family Service Association of America, National Council on Crime and Delinquency, and the National Traders Aid Association, has found gross deficiencies in general assistance programs—programs established by States and localities to aid needy persons who do not fall into the categories for which Federal aid is available. From State to State, and even from locality to locality within States, the amount of assistance provided through such programs varies from essentially nothing to amounts approaching those of the federally aided categories.

In many States, certain types of families are excluded entirely from receiving assistance, especially the families which are nonresidents or in which the parent is deemed physically employable—whether or not a job is available.

In one community studied where the families employable were excluded from public aid, the only assistance available to them was a weekly grocery order of \$2 per person from the Community Chest or the Salvation Army. Archaic methods, such as giving assistance in kind, are still being used in many places. One local relief administrator reported that on occasion he required persons asking for new shoes to turn in their old shoes first, to be certain that they were entirely worn out. Yet, in spite of the seriously low standards in general relief, only about one-third of the States (18 in November 1964) have tak-

advantage of the provision of the 1962 Amendments to the Social Security Act, allowing them to expand their federally aided AFDC programs to include the families of unemployed parents.

Obviously the recommendations of the 1960 White House Conference calling for more adequate assistance for needy children are far from attainment. In order to place the kind of floor under family income which is necessary to end conditions of abject poverty is the nurturing ground for millions of children, major improvements in current assistance programs are still required.

It appears that the time may be overdue for serious consideration of some new approach to assuring income to families with children. One White House Conference recommendation, for example, called for study of the family allowance system used in Canada and other countries to offset the inverse relationship between income and size of family. (Recommendation 111.) The relationship between minimum wage laws and the protection of children, pointed up in the Conference recommendations, cannot be overlooked.³ (Recommendations 434 to 436.)

The strong concern of the participants in the 1960 White House Conference for strengthening family life led them to consideration of the resources represented in AFDC and in child welfare services. They specifically recommended lower caseloads in these programs and more clear-cut assignment of responsibility for casework to families which were giving inadequate care to their children.⁴ (Recommendations 104 and 449.)

Congress in 1962 opened the way, in both of these programs, for extensive implementation of these recommendations. Not only did it clearly charge the AFDC program to provide welfare services likely to prevent or reduce dependency and promote self-reliance, but it also provided the wherewithal to move in this direction. In addition, it required special attention to the needs of each child in the program and the provision of appropriate services. States complying with Federal standards can now receive 75 percent reimbursement for the cost of certain social services in AFDC, including casework and complementary services such as social group work, foster family care, homemaker, social rehabilitation, and volunteer services and for staff development activities. Among other standards which must be met to attain eligibility for this reimbursement is one requiring that caseloads be no higher than 60.

As a result of these provisions and a number of other important changes affecting the AFDC pro-

gram, all States have made some program improvements. By September of 1964, 53 of the 51 States or other U.S. jurisdictions had developed plans for qualifying in some degree for the 75 percent Federal matching funds for social services in AFDC. Six States had sufficient staff to meet the Federal caseload and supervisory standards and also were providing the full scope of services to all AFDC families, as needed.

In spite of serious problems in recruiting and training staff for these difficult casework assignments, there is every reason to think that there will be much forward movement in the development of service in this program over the next several years.

Child Welfare Services

In a comparably significant action, Congress also redefined the Federal child welfare services program. Its new definition of child welfare clearly pits that program against those problems "which may result in the neglect, abuse, exploitation, or delinquency of the child." The definition recognizes the value of strengthening the child's own home, where possible; focuses on prevention of problems, as well as remedy; and encompasses services designed to reinforce the ability of parents to meet the child's needs.

These services include: casework with children and with parents, provided either upon request from the parents, or, in situations where action is necessary for child protection, upon community referral; services to unmarried parents focused both on planning for care of their children and resolving their own problems; supplementary child-care services, such as homemaker and day-care services, to compensate for certain inadequacies in parental care; and a variety of services to substitute for parental care, when necessary, including foster family care, various kinds of group care, and adoption.

New importance is given to this rather comprehensive definition by another section of the law which provides that child welfare services be extended "with a view to making available by July 1, 1975, in all political subdivisions of the State, for all children in need thereof, child-welfare services provided by the staff (which shall to the extent feasible be composed of trained child-welfare personnel) of the State public welfare agency or of the local agency participating in the administration of the plan in the political subdivision. . . ."⁵

In requiring extension of child welfare services to all jurisdictions by 1975, Congress was directing its efforts toward one of our serious national problems—

the lack of comprehensive child welfare services in many parts of the country. In fact, in many of the counties in this country, essentially no child welfare services exist.

During the past 5 years, the National Study Service has examined public and voluntary child welfare services in approximately 20 communities. In many of these, the development of child welfare services has been only partial. In most of them, community action is likely to be taken in a child's behalf only if neglect or parental mistreatment has been serious and extended over a long period of time. This action is then likely to take the form of emergency removal of the child from the custody of his parents and placement in some kind of substitute care. Few were the communities in which neglected children were identified early, and they and their parents given skilled casework services aimed at early resolution of problems and prevention of more serious ones.

This failure to provide preventive services for children who are still with their own parents is widespread. It is the major finding of a statewide study of children's services in a large, highly populated State recently made by the National Study Service. That it is true in many other States is borne out by the Children's Bureau statistics. On March 31, 1963, for example, of the estimated total of 619,000 children being served by public and voluntary child

welfare agencies and institutions, only 41 percent were listed as living in the homes of parents or relatives or in independent living arrangements.⁷ The remainder were in foster care or in some other living arrangement away from their own parents. This underscores the need for a major push, between now and 1975, to enable States and localities to throw greater efforts into strengthening families in order to prevent the problems which result in the placement of children away from home.

Observations in a number of localities also indicate that little effort has been directed toward building services which supplement family care, such as day-care and homemaker services. In the statewide study already mentioned, homemaker services were found to exist in only 15 out of 58 counties, and therefore for the most part on such a small scale that they can be regarded only as demonstrations.

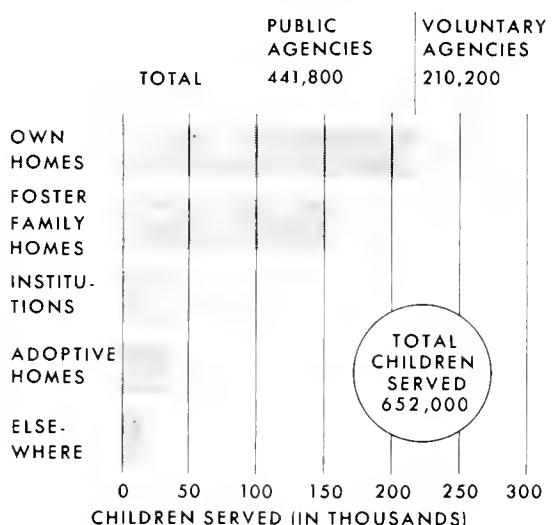
Although the leadership made possible in the States by the recent Federal legislation for day care is beginning to stimulate interest and new activity in this field, expansion in most localities has not been commensurate with need. Among many pressing problems is the shortage of child welfare workers in day care, resulting, for example, in the overburdening of licensing workers in numerous communities. There is also comparatively little availability of day care service for families unable to pay the full cost of care, and little use of day care as a planned source in a treatment program for a family. However, State plans for stimulating day-care services for those most in need of them and for strengthening licensing programs, have recently been adopted in 49 States with the help of Federal funds for day care made available in 1963, and the picture may improve in the future. In some communities, too, there are indications that the emphasis on poverty may result in significant expansion of day-care facilities.

The most extensive single child welfare service in most communities is foster care. Here, too, services have developed unevenly and are not necessarily related to need. Some communities are still caring for the vast bulk of dependent children in institutions. Others are operating with almost total dependence upon foster family care. While there is growing interest in the development of other varieties of foster care, such as agency group homes, such facilities are as yet comparatively rare.

Service to unmarried mothers in many communities is focused primarily on planning for the baby adoption, with a minimum of emphasis on the mother's future adjustment. In some communities, ad-

CHILDREN RECEIVING CHILD WELFARE SERVICES

By Living Arrangements, March 31, 1964



The gray portions represent children being served by public agencies; the striped portions, children being served by voluntary agencies. Source: Children's Bureau, Division of Research.

tion services, whether public or private, are restricted almost exclusively to easy-to-place children and meet only a comparatively small portion of the need. Although the proportion of children adopted by nonrelatives who were placed by social agencies has steadily increased in recent years (66 percent in 1963 compared with 59 percent in 1960), in some States less than half the children adopted by nonrelatives were placed by social agencies.

Obviously, much remains to be accomplished before comprehensive child welfare services are actually available throughout the country. Some deficiencies can be directly attributed to inadequate financing. Everywhere there is great concern about the cost of child welfare programs. In all communities studied by the National Study Service, financial resources for child welfare services have been extremely small, as compared with the needs of children. In fact, much of the preoccupation of child welfare workers with foster care probably goes back to budgetary pressure. A child in an emergency situation who cannot be looked after by his parents naturally receives first consideration by the community child welfare agency. If this agency is bogged down by high caseloads and meager resources, it may never get much beyond the handling of emergencies. Some of the agencies studied were found to be essentially in this condition.

The findings of the 20 studies completed by the National Study Service give us every reason to think that a tremendous expansion of services is needed for achieving universally available child welfare services. This will require the addition of new services, additional staff in existing services, and additional child-care facilities.

Such expansion will be expensive, and it is not likely to occur unless a drastically different approach is taken to the financing of child welfare services. At present, meeting the cost of these services rests primarily upon the States and their subdivisions. In some States, most of the cost must be met by the local community. This is in contrast to the situation in public assistance.

It was recognized long ago that if public assistance programs with reasonable standards were to exist in all subdivisions in each State, heavy Federal financial participation and strong Federal leadership would be required. This recognition found expression in the Social Security Act's authorization for an open-ended appropriation to help meet the costs of State public assistance expenditures through a matching formula. As a result of this assumption of responsi-



Children enjoy stimulating experiences in a Washington, D.C., research-oriented day-care project which is conducted by Howard University, with the support of the Children's Bureau.

bility by the Federal Government, public assistance programs long have been available to needy residents of the remotest county in the Nation. On the other hand, Federal funds for child welfare services—which are limited by ceilings on authorized appropriations—have been available only in comparatively small amounts for purposes of strengthening State leadership and stimulating the development of services. Federal funds for child welfare services have been increased over the years, but still are so limited that they can only be regarded as a leadership tool, rather than as a source of financial support for local services.

Child welfare services of the kind visualized in the new Federal definition are basic services which must be made available to children who need them, regardless of the jurisdiction in which they live. If these services were provided properly, and in the amounts necessary, their cost would far exceed current expenditures. Local officials in the communities we studied were usually so burdened with local tax problems that they showed little disposition to finance a child welfare program on the scale necessary to provide the preventive and rehabilitative services visualized in Congress's definition. While in recent years some States have been assuming greater financial responsibility than formerly for child welfare services, there is little likelihood that

all the basic services will be available to all children needing them until the Federal Government assumes financial responsibility for this part of public welfare comparable to that assumed for public assistance. This means substantial Federal reimbursement to the States for the cost of care and service and for administrative costs.

Personnel

Lack of funds is not the only barrier to the extension of social welfare services for children. Serious problems also stem from the lack of professional personnel. There was strong emphasis on this subject in the 1960 Conference, and many recommendations were made concerning the recruitment, training, and retention of personnel in the helping professions. (Recommendation 443.)⁵ Since that time numerous advances have been made.

The impetus from increased Federal funds for training public assistance workers, authorized by the Public Welfare Amendments of 1962, has resulted in considerable acceleration of training activities in the States. At the present time, there are about 400 persons in staff development positions in State and local public welfare agencies. About 1,495 public assistance staff members were on educational leave during the year ending June 30, 1964. And about 1,000 child welfare workers were provided stipends for professional training with Federal and State child welfare service funds during 1964, as compared with about 600 in 1960.

In addition, under new provisions in the 1962 legislation, Federal funds were made available through the Children's Bureau for grants to institutions of higher learning in 31 States, the District of Columbia, and Puerto Rico to expand their resources for training child welfare personnel. With these grants, 53 new field instruction units were established, adding facilities for about 275 students; and 276 traineeships were made available to schools of social work to bring new people into the field.

While these activities represent important progress along the lines of the White House Conference recommendations, their significance becomes dwarfed in the face of present and anticipated needs. Fred Steininger, director of the Bureau of Family Services, after describing current training and recruitment efforts in public assistance, concludes that in spite of these advances "... there is no indication of any significant change in the 1960 ratio of 1 professionally qualified caseworker for every 23,000 assistance recipients."⁶

The strong emphasis of the Children's Bureau on staff training has played an important role in helping many States to develop a fairly high level of professionally trained staff in their child welfare services. The competition of other programs, however, and the greatly expanding need for staff which is accompanying the extension of child welfare services are making rapid inroads on the progress in reducing the shortage of qualified staff. Unless radically different approaches can be developed for the training and use of personnel, even more serious problems lie ahead.

Research

As in any social welfare endeavor, lack of knowledge frequently stands in the way of success in child welfare services. For this reason, recommendation calling for research relating to child welfare services were made by the 1960 White House Conference.⁵ (Recommendations 380 and 381.) For this reason also, child welfare research has greatly accelerated in the last 5 years. For example, the Child Welfare League of America has enlarged its research role. The child welfare research and demonstration grants program administered by the Children's Bureau has opened up new opportunities. Grants for research relating to children in public assistance programs are available from the Welfare Administration. The sum of these programs, plus the research in child welfare being carried on by many other groups, cannot approach the research effort in the health field; but it is a beginning.

Coordination

Some of the problems discussed at the White House Conference related to the organization of children's services; and some of today's difficult unanswered questions are in this area. As a surveyor, it has frequently been my job to examine the family and child welfare agencies of a community to determine the degree to which they are effectively operating together in the protection and care of children. Too often, I have found agency administrators and practitioners pressing the development of their own specific type of service with little thought as to how it may be related to others in solving a general problem, such as dependency, parental inadequacy, or delinquency.

In many communities, agencies serving children are so specialized and their services are so fragmented that no one seems to be concerned with the whole family or even the whole child. Too often, when a

child needs a change in service—as from the home of a relative to a foster home—the change results in a change of the child's worker and even a shift to an entirely different agency. Each time this happens, whatever has previously been gained in building a worker-child relationship is lost, and it is necessary to begin again, frequently to the detriment of the child.

Some of the questions in need of clarification center on the role of voluntary agencies and their relationship to public services. Voluntary agencies play an important part in the provision of child welfare services. Although the proportion of children being served by public agencies is increasing, 33 percent of the children receiving child welfare services on March 31, 1963,⁷ were served primarily by voluntary agencies. Voluntary agencies, however, are unevenly distributed with heavy concentration in some urban areas and almost no services in many rural areas. Some communities are unrealistically attempting to provide care to most of the children who need it through voluntary agencies, which must draw on public funds for the purpose. In this failure to differentiate between public and voluntary responsibilities, the essential characteristics of voluntary agencies—flexibility and self-determination—are sometimes sacrificed. Both public and voluntary services are needed, and it is to be hoped that both can support those advances and changes which are required to meet the needs of children and together can work out increasingly productive relationships.

Frequently, problems of overlapping functions arise between public agencies. This is particularly true in some communities in relation to probation and public welfare. This lack of clarity is particularly serious in relation to protective services for neglected or abused children. Sometimes this confusion also extends to foster care.

Sometimes also child welfare staff and public assistance staff are not well coordinated and fail to work for common goals in a particular family. The 1962 Public Welfare Amendments require coordination of these two programs within the States; and

State plans under both programs now must show how this is to be achieved. There is, however, still much to be done toward better coordination of the programs at all levels of government. The recent establishment of the Welfare Administration gives great promise for accelerated progress in this direction, as well as for increased recognition throughout the country of the importance of public welfare programs.

Many people can identify the problems of agency organization, role, and function which inhibit the provision of sound service to children; but so far only inadequate answers have been found to most of them. This is an area requiring major attention.

It has, of course, been impossible in this short space to give an adequate review of the status of child welfare services in 1965, nor even of the issues remaining unresolved since the 1960 White House Conference. The developments and issues which have been pointed out here are, however, some of the most significant of the past 5 years. It is obvious that progress has been made since 1960 in meeting the welfare needs of children and that we are on the threshold of great opportunity. It is also obvious that some serious obstacles must be removed if we are to meet expanding needs. Their removal will demand much ingenuity and the concerted efforts of all.

¹ Public Law 87-543.

² Public Law 88-156.

³ Witmer, Helen L.: Children and poverty. *Children*, November-December 1964.

⁴ "The Economic Opportunity Act of 1964." *Children*, September-October 1964, page 198.

⁵ Golden Anniversary White House Conference on Children and Youth: Recommendations—composite report of forum findings. National Committee on Children and Youth, Washington, D.C. 1960.

⁶ Kahn, Gerald; Perkins, Ellen J.: Families receiving AFDC: What do they have to live on? *Welfare in Review*, October 1964.

⁷ U.S. Department of Health, Education, and Welfare, Welfare Administration, Children's Bureau: Child welfare statistics—1963. CB Statistical Series No. 75. 1964.

⁸ Steininger, Fred H.: Implementation of the 1962 Public Welfare Amendments. *Welfare in Review*, October 1964.

. . . deprived children, whether in their own homes or out of them, are a source of social infection as real and serious as are carriers of diphtheria and typhoid.

John Bowlby in Maternal Care and Mental Health, World Health Organization Technical Monograph Series No. 2, Geneva. 1951.



FERMENT IN THE SCHOOLS

SIDNEY P. MARLAND, JR.

Superintendent of Schools, Pittsburgh, Pa.

AMONG the 670 recommendations made by the 1960 White House Conference on Children and Youth, 123 were concerned with education. It therefore seems fitting at this mid-point between Conferences to assess the progress being made toward the goals set 5 years ago.

In the 25 years I have been a public school educator, as teacher, then administrator, there has been at no time the heightening of public concern, support, and involvement in the affairs of public education that prevails in 1965. These are good signs for the future of education, and, though this public enthusiasm may not last, there is no evidence, so far, of a decline or even of a leveling off.

Today, the voices of top business and industrial management as well as high government officials are heard clearly among those who call for increased investment in the human beings of our society through the schools. And even the scholars of the universities have learned to respect the public schools—perhaps the most significant development of all.

In the schools themselves, a spirit of innovation is spreading, although movement is still cautious. Also, there is a new academic vigor which can be measured by the opportunities now available to the ablest children—advanced placement programs and a variety of efforts to stimulate the intellectual appetite of swift learners at all grade levels. And a greater investment in public education is being made.

During the past 10 years, yearly expenditures per pupil have increased from \$265 to \$460, the bulk of the increase going to teachers' salaries and slightly improved pupil-teacher ratios.

All in all, public education is enjoying a prestige,

a concern, a visibility, and an acknowledged responsibility that suggest a time of full flowering.

Yes, But . . .

Lest these favored circumstances bring on an unwarranted optimism, let us examine the other side of the ledger. Here are the liabilities:

1. Unequal Access

In a land founded on a belief in equal opportunity . . .

- One of every three students in fifth grade drop out of school before high school graduation. While the proportion of dropouts has been declining for the past 50 years, it is still large enough to indicate that, for far too many young people, the schools have failed dismally to provide a relevant education.

- More than 20 percent of our high school students in the 80-90 percentile of academic attainment do not enter college in the year following their graduation—many of them never get beyond high school.

- Fewer than 2 young citizens in 10 now graduate from college.

- While 69 percent of our young white adults have graduated from high school, only 42 percent of our young nonwhite adults have done so.

- While 14 percent of our young white adults have completed college, only 4 percent of our young nonwhite adults have done so.

2. Insufficient Money

In a period of unmatched economic prosperity and growth . . .

- We have an urgent need for more than 120,000 new classrooms.

- The financing of education remains largely in the backwaters of anachronistic property taxes and qualification formulas for State aid that enhance inequality. Yet by the time the 1970 Conference convenes, public elementary and secondary school enrollment will have increased to nearly 45 million pupils, from 36 million in 1960.

- Teachers' salaries, in spite of improvements, continue to lag behind general salary gains of professional and managerial personnel nationally. About 23 percent of people in professional and management occupations in this country generally earn over 10,000 a year, while among classroom teachers in the public schools only 1.5 percent earn over \$10,000. At present salary rates, the schools cannot compete with the "professional and managerial" world for their fair share of the young people capable of being teachers.

- A momentous population shift is occurring with deeply damaging results in our big cities. Total big-city population (in the 15 largest cities) decreased 1 percent in the past 10 years, while public school enrollment in these cities increased 33 percent. The bonded debt for buildings, not to mention the moral debt to deprived central city residents, is left behind by the out-migrants, for the most part people in the higher income brackets. The shrinking tax base remains as an eroding resource for an enlarging educational burden, including the burden of compensatory education for newcomers who come from inferior schools.

3. Insufficient Vision

In a time when computers and other automatic devices are drastically affecting the types of jobs available, the schools act as though the world of work were the same as it was 20 or 30 years ago. In the chemical industry, between 1956 and 1961, output increased 38 percent while production jobs dropped 4 percent. Between 1955 and 1961, the jobs in the steel industry dropped by 126,100, while steel capacity increased 18 percent. The single farm hand could feed 26 persons in 1963; only 11 years ago, he could feed only 15. Yet . . .

- We have no educational plans at this time to equip children for the dislocations to come as a result of automation and the computer.

- Vocational education offerings in the public schools lag far behind the realities of business and industry in terms of content, equipment, and staff training.

- One million boys and girls leave school each year

without a high school diploma. Yet fewer and fewer jobs are available for persons who have not completed high school.

- The popular attitude toward occupational, vocational, and technical education, among pupils, parents, teachers, and even counselors, reflects an intellectual snobbery that has critically curtailed the overdue revival of this arm of public education.

4. Separate and Unequal

The nonwhite population of our schools in some Southern States and in many large Northern cities are at an educational disadvantage:

- While many nonwhite boys and girls are enjoying a whole and rewarding school life, the great majority are not.

- In spite of declarations by State departments of education, human relations commissions, and the U.S. Department of Health, Education, and Welfare charging school leaders with the responsibility for active racial integration measures, the literal, physical task of integration remains a frustrating, unsolved problem.

- The big cities face a rapidly changing social composition in their pupil enrollment, as more and more middle-income white families move to the suburbs, leaving in the city families who cannot depart, for reason of color or poverty or both. This trend must be reversed, not only for the good of nonwhite boys and girls and the economic health of the cities, but also so that the children of the self-segregated white families can get, through a desegregated education, a better idea of the world they live in.

- In spite of serious efforts to break down the Negro ghettos by some means, such ghettos still remain in the North as well as in the South.

- Teachers in the schools in these Negro ghettos are (with many wonderful exceptions) of lower professional calibre than elsewhere. "Permanent" substitutes are more frequent. Classes are apt to be larger. Buildings are older, having been a part of the old central city. In such schools, hope is dimmer and pupil achievement is measurably much lower. Although there are in the large cities many public schools with mixed social populations, where teaching and pupil achievement match the best of the schools in high-income suburbs, the educational picture as a whole gives little promise for any early solution of the problem of providing equal educational opportunity for children not only *among* States but *within* States and cities.

- The deep poverty of many families, both white

and nonwhite, produces barriers to education that have not yet been truly comprehended in our educational programs. Third generations of families supported by public aid suggest a segment of our population living in chronic social dependency that the schools have not shaken.

While these dismal unresolved issues do not alone give a true picture of education at the mid-point of the decade, they are reminders of urgent unfinished work, which is hardly begun.

The Brighter Side

Good things are happening in the schools. Perhaps the most promising developments that have taken place in this century are now going on in classrooms and educational planning councils across the land. Of great significance in this ferment are two forces: the increased availability of Federal funds for educational purposes; and the leadership by prominent national figures now reinforcing the movement for improved public education.

In spite of the aid-to-education controversy, major allocations of Federal funds are being placed in support of the public schools. This trend is compatible with one of the strong admonishments of the 1960

White House Conference: "That the Congress of the United States affirm . . . the . . . support of public education . . . authorizing substantial, continuous and general financial support to the States. . . ." (Recommendation 116.)¹

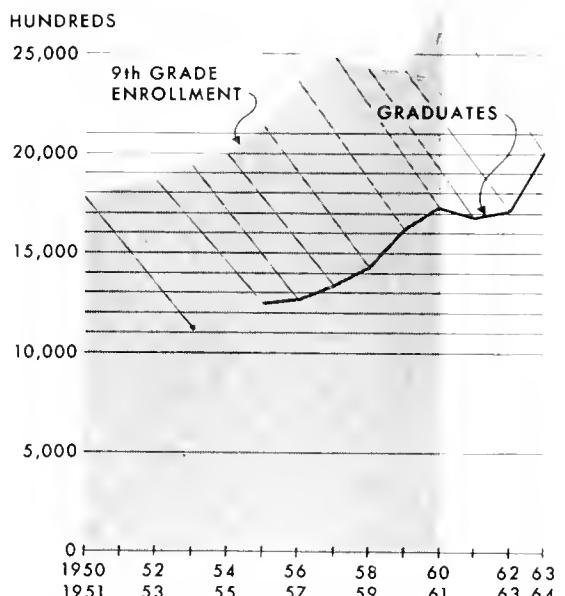
Since 1959, the *National Defense Education Act* has infused grants and loans into education's bloodstream totaling, to 1964 about \$1 billion. The 1964 rate was \$250,788,000, about three-fourths of 1 per cent of the Nation's educational expenditures. But the impact has far surpassed this quantitative proportion. Nearly half the student loans have been made to young people from families with annual incomes under \$4,000. The number of full-time counselors or their equivalents has increased 150 per cent during NDEA's short period of influence since 1959. Both quantity and quality of high school mathematics, the natural sciences, and foreign language courses have increased. Course offerings and enrollment in technical education for high school students have increased fourfold during the period. The 1964 legislation broadened the scope of NDEA to include support for the full range of academic offerings in the public schools, thus departing from the military rationalization of the initial enactment. Support of institutes for intensive education of teachers in service in 1965 totals \$37 million.

The *National Science Foundation*, as an equally powerful Federal instrument, is supporting the upgrading of about 40,000 science and mathematics teachers a year, most of them at high school level. During the past 10 years, 236,000 teachers have been involved in NSF retraining programs at a Federal cost of \$259 million. The Foundation also supports other programs to improve science education in the schools, including research participation and special seminars for high school students, course-content improvement projects, and the provision of curricular material.

The *Cooperative Research Program*, administered by the Office of Education, U.S. Department of Health, Education, and Welfare, is spending about \$16 million a year in encouraging the partnership between universities and public schools toward the development of new curricula in all academic fields. The education of handicapped children has also received long overdue attention through this activity.

Vocational education, including its new dimensions—occupational education for the slow and technical education for the swift—has found a new and lively place in the public schools through intensive Federal support. Modernization of course offerings

NINTH GRADERS WHO WENT ON TO GRADUATE



The shaded portions show ninth-grade enrollment as of the school year indicated at the bottom. The diagonal line shows how many students graduated 4 years later. Figures for graduates who were ninth graders in 1951-52 are not available.

retraining of teachers, upgrading of facilities and equipment are heavily encouraged in legislation passed in 1963. In 1965, over \$118 million will flow to the public schools through this program, with increasing appropriations authorized for subsequent years.

In addition to this direct support for the public schools, the Federal Government has increased its support for libraries, research in mental health, and, under the Manpower Development and Training Act of 1962, vocational training. In 1964, the Federal expenditures for instruction alone totaled \$79 million for 128,000 MDTA trainees, most of them adults studying in the public schools. Other Federal aid to education is given in the form of educational television; increased service to State departments of education; and the new Job Corps, work-training, and work-study programs under the Economic Opportunities Act.

Thus, while "general" Federal aid to education remains a controversial issue, substantial and highly effective Federal support is flowing to education today. Whether general or categorical—whether by grants, or by the circuitous route of an antipoverty program—whether or not infringing on local control (defense of which is often an excuse for safeguarding mediocrity)—desperately needed funds for the support of public schools are likely to flow increasingly from the Federal Treasury during the next half-decade.

Fresh Leadership

Leadership for improving the public schools has in recent years come from many persons of high standing, including top Federal officials and persons distinguished in other fields. Undoubtedly the most stimulating is the scientist James Bryant Conant, former college president and ambassador, who has become the dedicated champion of the public schools and a constructive contributor to their evolution. His nine books on education since 1945, from "General Education in a Free Society,"² to the most recent, "Shaping Educational Policy,"³ have set school leaders throughout the country to rethinking the structure, policies, and methods of public education and teacher training. For example, his "Slums and Suburbs,"⁴ probably had as much to do as any of a number of converging forces with shifting the main stream of educational innovation, inquiry, and investment away from the suburbs and back to the big cities, where the numbers, problems, and potentials are of highest significance.

Countless other scholars have also provided constructive criticism of education today—the psychologist, Bruner of Harvard; Cremin, historian and philosopher; Zacharias, the physicist; Ralph Tyler, social scientist, to name only a few, all of whom have offered provocative suggestions for making schools into places where children might learn more effectively. Professional educators have a powerful new resource in this swiftly emerging concern of the scholars. Those who fear it or reject it have, themselves, already stopped leading.

Innovation

A third powerful force now emerging in the 1960's is a spirit of inquiry, change, experimentation, and critical thinking. Perhaps this new spirit is in part a product of the first two; but I think it would have come in any case.

There was a time, and there still is in some communities, when the term "educational experiment," or "research," was anathema. Boards of education that believed in the need for innovation found ways to camouflage any such item in the budget, lest it be noted by a suspicious public. School superintendents cloaked their innovations in cautiously phrased descriptions of activities "being tested for a trial period." Faculty committees, whose democratic consensus was sought on changes under consideration, either balloted not to change, or so reconciled differences as to remove any red blood from the experiment.

These circumstances seem now to have been overcome in most lively school systems. Any superintendent who does not have a notice of a recent research grant in his pocket, or an application for one, is likely to be pitied by his counterparts elsewhere. This, unfortunately, implies that good educational inquiry and innovation need some kind of outside money in order to flower. We will, I hope, pass through this period of relying wholly upon the Federal Government or large private foundations for getting the pump primed, and put research and development into their proper places as a function of the budget. We can continue to count on special grants for work on the cutting edge.

But the fact remains that innovation and change are fruitfully with us—including the opportunities for exciting and rewarding blunders. To those who, in defense of the "captive" children, raise cries of caution, I would reply that educational innovation, no matter how unsuccessful in a trial period, is likely to have little, if any, damaging effect on children.

Further, the offsetting excitement and intellectual adventure of participation is likely to prove an asset for the learner, no matter how dismal the "experimental failure." In fact, the mighty powers of fellow faculty scrutiny, parent opinion, fiscal curbs, and historic tradition are so ever-present that the child's education is well safeguarded against injudicious experimentation.

The aspects of education in innovative ferment are too numerous to be catalogued here. But they can be classified as dealing with four broad categories: (1) the learning process; (2) the technology of instruction; (3) the evolving curricula; and (4) the teacher.

The Learning Process

Among all the things educators admit to understanding only slightly is the process of learning itself. In this decade we are groping, with powerful allies from the field of child development, to learn more about learning. Numerous experiments are going on today to test ways of preparing young children for school—particularly children of the culturally deprived—and these are giving clues to the broader question of how children, in general, learn. They have underscored the growing realization of the importance of early stimulation to later learning. As a result, some school systems—for example, Baltimore and Pittsburgh—are experimenting in lowering the age of school entry for children from disadvantaged homes.

These and other inquiries into the way children learn have led to the following:

- A relook at the meaning of the "IQ," accompanied by an increased respect for creativeness.
- A search for relevant predictors of the potential of children from deprived neighborhoods. This has further shaken the educator's reliance on traditional intelligence tests.⁵
- The birth of occupational education—work-study programs of learning for high school boys and girls with low ability, low aspiration, and low academic performance. Society, no longer having a place for the dropout, can no longer tolerate the schools' abdication of its responsibility for the large portion of young people who are not stimulated to learn under the schools' regular programs. New teaching techniques, a different school day and year, different motivations and rewards, different goals will characterize this innovation, now barely off the ground.
- An increased curricular disparity between the very able and ambitious and the very slow but edu-

cable. One of the most spectacular successes in this period of educational ferment is the advanced placement program for swift learners. The achievements of young people in these programs have given educators a far greater appreciation than they once had of the mind of a 14- or 17-year-old.

• Investigations into ways of stimulating the learning processes of the emotionally disturbed child, the child with cerebral dysfunction or brain damage, the underachiever with a good mind not yet in motion. Much more needs to be learned about how atypical children can be helped to learn.

• Efforts to build a taxonomy of education. This will have heavy influence on testing and measurement, and thus on the processes of teaching and learning.

• A concern with providing compensatory education, from kindergarten through junior college, for persons previously deprived of appropriate educational opportunities.

• An evolution away from stereotyped classes and teacher-pupil ratios, including such innovations as team teaching, ungraded schools, and a rededication to individualized instruction.

The Technology of Instruction

Closely related to developments concerned with the learning process are the technological innovations now used in the teaching process. While the usefulness of many is still unproved, their prognosis is strong. For example:

• *Educational television's* worth as a powerful tool of learning within a school system is now becoming clear. The horrendous problems of scheduling, the fear of outside domination, the insecurity of teachers appear to be overcome as an appreciation develops of this means for deploying a distinguished teacher among thousands, rather than scores.

• *Programed instruction*, through the use of teaching machines or programed textbooks, though still not visibly affecting the main stream of education is proving to be a valuable method for helping individual children to progress at their own learning pace. While the present devices have some shortcomings, the increased devotion to individualized teaching calls for an increase, rather than a rejection of programed materials.

• *A variety of mechanical aids* for the teacher have become accepted classroom devices in the sixties. Among these are: the overhead projector, a device which allows even the technologically unsophisticated teacher to create and project visual materials.

o emphasize her points; the 16 millimeter movie film and the television tape, used as springboards for class discussion; the tape recorder, especially useful in individualized instruction in spelling, English, and foreign languages.

• *The learning laboratory* is beginning to appear in some schools. This is a place—sometimes in the school, sometimes a mobile unit which goes from school to school—where the resources of instructional technology, the library, and a wise and creative teacher can be pooled for self-motivated, high-powered, individualized self-instruction, starting at about grade six or seven. Conceivably, the digital computer will one day be part of its equipment, not only as a device for information retrieval but as an instrument for self-teaching.

The effectiveness of all these mechanisms of instructional technology depends upon the quality of the program within their mechanical perimeter, and the degree of imaginative and nondefensive application by teachers.

The Evolving Curriculum

Teachers have long held that curriculum is by definition a process of constant and unrelenting innovation and evolution. But the tempo of change is faster today; the span of change larger; the acceptance of change more affirmative.

The change is heavily influenced by the preoccupation with increased academic rigor; by men who have brought top scholarship into a fruitful marriage with top teaching, planning, and design; and most of all by teachers who have themselves achieved a new self-esteem by demanding more of themselves and of children, and have found satisfaction on both counts.

The curriculum is responding swiftly to the modern surge of interest in mathematics and science. There are also new and steadily growing emphases on the language arts and social studies, manifested by the introduction of linguistics; a relook at methods of teaching reading; the systematic articulation of reading with the other academic content materials; and the conversion of social studies to the inductive method. And recently an emerging concern about the humanities is beginning to make itself felt, especially in the high schools.

Experimentation today has shed the esoteric trappings of a cult or "school," which burdened the progressive movement of the 1920's, and has become the rational choice of teachers and scholars at large. It is encouraged by the perceptive shift of large founda-

tion resources into the developmental activities of the public schools.

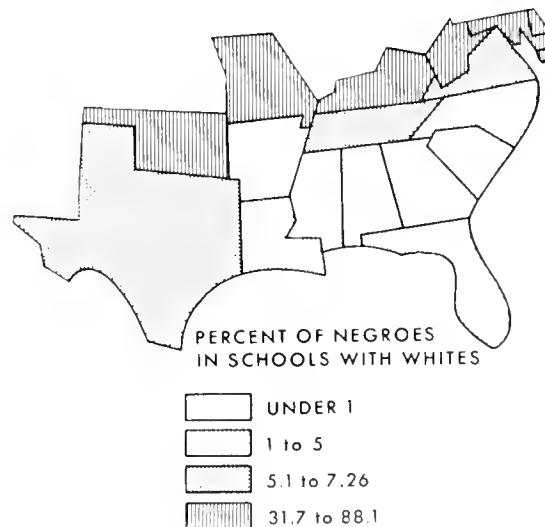
The Teaching Profession

The large variable that escapes ready description in this period of innovation is the profession of teaching itself. The effects of a massive force of 2 million professional people cannot be comprehended in any brief stock taking. But certainly the corporate body of teachers is a part of today's educational ferment, along with the countless individual teachers who comprise it.

The variables within the profession are monstrous. In one State, for example, the average teacher's salary is about one-half that in the State with the highest average. There are States where 2 years of post high school education are sufficient credentials for teaching, while in other States 5 years are now required. Twenty-five percent of our high school mathematics teachers did not major in mathematics. The same is true, in varying degrees, of teachers of other subjects.

The tempo of education in the mid-sixties and the new expectations of our society call for two large responses by the education profession: to bend itself to continuous, systematic, and high quality inservice education at all levels; and to discover and champion the design for attracting into teaching a larger share

SCHOOL INTEGRATION IN THE SOUTH, 1964-65



The map, based on figures from the Southern Education Reporting Service, shows considerable progress toward school desegregation in some border States. In West Virginia, for example, 88.1 percent of Negro school children are in schools along with white children, and in Kentucky, 62.5 percent.

of the ablest young people choosing a career. On both counts the organized teacher has made heavy efforts, but too often these have been hampered by a crouching posture of defense—a preoccupation with salary recognition and with compensation for out-of-classroom work and inservice training.

In efforts to recruit wise and good young people for teaching, the profession has a distinguished record. Selfless commitment to supervising student teachers; sponsorship of future teacher groups, both formal and informal; constant persuasion of promising youth toward a teaching career are clearly on the record.

But so far these measures are not enough. The teaching profession over the next 10 years will require 1.7 million new people to staff the schools. This is approximately the number now employed!

We must find ways to elevate the teacher as a dignified and responsible professional person. Boards of education must provide the machinery through which teachers can assume a larger role in formulating educational and personnel policies and, within the limits of legal authority, give constructive response to teacher initiative. Boards must also seize the initiative in designing and funding dramatic salary improvements for teachers. Otherwise, teachers will increasingly look upon boards of education as adversaries, and will take collective measures to struggle *against* the administration and boards, rather than struggle *with* and *for* them.

The good things that are happening in the teaching profession are sound and promising. The thousands of teachers who have responded enthusiastically to the inservice educational opportunities of the National Defense Education Act, the National Science Foundation, and the cooperative research programs of the Federal Office of Education provide substantial testimony to the profession's vigor and vision in this mid-decade. The flowering of Master of Arts in Teaching programs in many universities gives liberal arts graduates a new corridor into teach-

ing. The self-evaluation going on in most teacher education institutions promises increased selectivity of teacher candidates and improved preparation of learned people for the classrooms.

Education For What?

In a recent work, "Education for Modern Man," Sidney Hook addresses himself to the issue of whether society can afford to be torn by a philosophical cleavage between the men of science and the men of the humanities. He writes:

Our schools must do many things but they will not teach us to understand other men and other cultures, other idea patterns and ideologies, merely by adding courses in mathematics and physics to the curriculum. . . . Moreover, the processes of social change have been just as opaque to humanists of predominantly literary culture as to natural scientists. The sneers that natural scientists sometimes direct against the . . . social sciences reveal a too-narrow conception of science, and an underestimation of the amount of knowledge, vague and inexact as may be, which we already bring to bear in controlling an understanding human behavior. The issues of war and peace, freedom and enslavement, international law and government in a world of cultural and social diversity are issues central to what may legitimately be called the "third culture."

In seeking to comprehend in these few pages the state of our schools at this mid-point in the decade, we have been aiming at a swiftly moving target. In this time of ferment, it is possible that education in America, through innovation, experimentation, and inquiry, is moving toward Hook's "third culture."

¹ Golden Anniversary White House Conference on Children and Youth: Recommendations—composite report of forum findings. National Committee on Children and Youth, Washington, D.C. 1960.

² Conant, James B.: General education in a free society. Harvard University Press, Cambridge, Mass. 1945.

³ ———: Shaping educational policy. McGraw-Hill, New York 1964.

⁴ ———: Slums and suburbs; a commentary on schools in metropolitan areas. McGraw-Hill, New York. 1961.

⁵ Hunt, J. McVicker: How children develop intellectually. *Children* May-June 1964.

⁶ Hook, Sidney: Education for modern man, a new perspective. Alfred A. Knopf, New York. 1963.

. . . what happens in kindergarten may largely determine whether a child will later be in college or on relief.

From "Educational Responsibilities of the Federal Government," report of the Educational Policies Commission, National Education Association, 1964.

INNOVATIONS IN COMBATING JUVENILE DELINQUENCY

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THE 1960 White House Conference on Children and Youth gave substantial attention to the problem of juvenile delinquency, and included among its numerous recommendations many focused specifically on ways of coping with the problem. What progress has been made toward their implementation? What remains to be done? In the light of what has happened during these past 5 years, do the recommendations still appear to be valid?

An exhaustive review of the many developments which have taken place in this short space of time would take a book. However, since much of what has occurred has been affected directly or indirectly by Federal action—action recommended by the Conference—it is appropriate to review this and its effect on community programs to combat delinquency.

The seeds for such action were, in fact, planted nearly a decade before the 1960 Conference.

Shortly after the previous White House Conference in 1950, a special juvenile delinquency project was established, located within the Children's Bureau but supported by voluntary funds and concerned with stimulating action across the country to cope with what was already defined as a serious national problem. Partly as a result of this project, Congress by 1955 had recognized the need for greater Federal leadership in this field. A Senate investigation had been launched and an appropriation had been made to allow the Children's Bureau to establish a Division of Juvenile Delinquency Service, offering expanded consultative services to States and local communities.

The 1960 White House Conference called for further expansion of the Federal role, asking that a Federal commission be appointed "to advise the President and Congress on matters relating to delinquency, including general coordination of Federal activi-

ties in this field. . . ." It also recommended that Federal funds be provided to State and local governments on a matching basis for programs of prevention and control of delinquency. In addition, the Conference called for expansion of the Children's Bureau anti-delinquency program, and for the provision of Federal scholarships in the behavioral sciences and of training grants to institutions following "the current pattern of training grants for the National Institute of Mental Health."¹ (Recommendation 525. Hereafter, specific recommendations will be cited by number only.)

Beginning in the late fifties, a number of measures had been introduced in Congress which anticipated some of the aims embodied in the recommendations of the 1960 Conference. In the Senate the late Senator Estes Kefauver and Senator Thomas Dodd of Connecticut were particularly interested in such legislation, as was Congresswoman Edith Green of Oregon in the House. Legislation was not passed, however, until after the election of President Kennedy. Then the Juvenile Delinquency and Youth Offenses Control Act of 1961 provided for many but not all of the measures advocated by the 1960 Conference. It broke new ground, however, in providing for direct grants to communities to help fight delinquency.

In anticipation of the act's passage, President Kennedy had established, through Executive order, the President's Committee on Juvenile Delinquency and Youth Development, composed of the Attorney General as chairman, the Secretary of Health, Education, and Welfare, and the Secretary of Labor; and a Citizens Advisory Council composed of persons of a variety of professions and interests who were especially concerned with the delinquency problem.

The Congress gave the committee a major policy-

making role in carrying out the provisions of the Juvenile Delinquency and Youth Offenses Control Act, but the responsibility for the act's administration was placed in the Department of Health, Education, and Welfare. Thus the policies adopted in making the grants were worked out by the Department in consultation with the President's Committee and its Advisory Council. In this article the resulting program will be referred to as the PCJD program.

Of major influence in the direction this program took were the theories of the sociologist Lloyd E. Ohlin, a professor at the Columbia University School of Social Work, who was brought to Washington, D.C., as special assistant to the Secretary of Health, Education, and Welfare at the suggestion of David L. Hackett, the executive director of the President's Committee. Dr. Ohlin gave the program a focus that resulted in its having a tremendous impact on the national conception of the problem of delinquency and of the most desirable approach to its resolution.

Theoretical Base

Dr. Ohlin's theories on delinquency had already been spelled out in a volume he wrote with another sociologist and social worker, Richard A. Cloward.² Their essential thesis, which has come to be known as the opportunity theory, is that most delinquency is bred in the slums where young people do not have real access to the ladders that lead to social betterment. Many such youngsters are victims of racial discrimination which has impeded their chances for living in decent housing, and for securing a good education, health care, and job placement. Whether victims of racial discrimination or not, children of the chronic poor, from whom the great proportion of delinquents are drawn, are—because of social, economic, physical, and cultural deprivations—severely disadvantaged in the race for life's material rewards by the time they reach kindergarten age.

Ohlin and Cloward suggest that such deprivations induce youngsters to turn to forbidden acts to achieve the gratifications that they cannot secure through socially sanctioned means. If this thesis is correct, then it follows that even the best individual treatment of the delinquent through clinics, courts, or institutions can do little to stem the tide of delinquency. At best, successful treatment would help the individual delinquent to develop his own capacities to the point where he could climb out of the social morass; it would not get at the root cause of the bulk of delinquency, which, according to opportunity theory, is in the social apparatus of the slum.

A derivative of this theory is the idea that what is needed to curb much of slum delinquency is nothing short of making the American dream come true for everyone. In other words, the successful antidelinquency program is one that provides for cultural, educational, and job achievement—not merely through general improvement of social institutions but through their specific adaptation to meet the needs of the socially deprived.

Prior to the passage of the Federal legislation work had begun on a program developed around opportunity theory, to be conducted on the lower East Side of New York City. This program was called "Mobilization for Youth" (MFY). An important part of its many-faceted plan, for example, was the establishment of new work-training opportunities. Among other projects, MFY induced leading oil firms to open a filling station for training purposes. A most important dimension of the MF plan is the development of social power among the heretofore relatively powerless residents of this deprived area, through helping them express their needs by use of the democratic process.

Mobilization for Youth became the first demonstration effort to receive funds under the Juvenile Delinquency and Youth Offenses Control Act. It is true that later programs supported under the act departed radically from opportunity theory, since the President's Committee and DHHEW required a theoretical orthodoxy but encouraged programs based on different theories; but it is also true that certain ideas related to opportunity theory gave important coloration to the total program—the emphasis, for example, on job and school achievement rather than on individualized therapy.

Emphasis on Planning

The act did not provide funds to be matched by State and local governments for ongoing services, as the White House Conference had recommended. It provided for support of research and demonstration projects and for training programs. Since the Federal funds authorized for the program were limited to \$10 million a year for 3 years (the program was later extended), the decision was made to use what was appropriated for a few massive demonstration programs, rather than for supporting many small service-oriented programs. This decision arose from the conviction that the direction of the program had to be toward major adaptation of existing institutions. Obviously, this could not be done by the type of single-service demonstration program with which

the welfare field has for so long been familiar.

Because institutional change was sought, the demonstration grants were generally preceded by initial grants for a planning process—a process which, being based on the gathering of facts and the delineation of problems, could serve not only as the basis for the development of programs but also as a base line to measure change resulting from programs. In this connection, it was held that the demonstration programs must represent not merely lip service to language that would produce funds but the convictions of those who could produce change about what changes were necessary. Thus it was required that planning for the demonstration involve the residents of the neighborhood where the program was to be launched, and also the decision-makers in town—representatives of business, labor, the clergy, women's groups, political leaders, and the like.

Since some of the conventional planning structures could not deliver the kind of planning process required, new *ad hoc* planning groups were formed in many communities. This fact alone gave rise to a reconsideration in many places of the relative merits of social planning and coordination as methods for attacking America's social problems.

The 1960 White House Conference had seen coordination in familiar terms. It had recommended a State citizens' committee with professional staff in each State "to achieve better coordination and effectiveness of all agencies." Largely as a consequence of the PCJD program, the emphasis on coordination of agency services that marked the White House Conference of 1960 will probably be absent in 1970. Today many people realize that while coordination is necessary for operation at maximum efficiency, it is essentially a process of negotiation between vested interests of equal power. Coordination makes what is more effective; it in no way insures that appropriate services will be effectively delivered to those most in need. To achieve this end, social planning is needed. The PCJD program definitely demonstrated that reliance on conventional coordinating devices is *passé* as a panacea for social problems.

Demonstration Projects

The PCJD made 16 planning grants. Of the communities which received these, about one-half received grants which enabled them to launch demonstration and research projects. Needless to say, these projects varied in quality and performance from "very weak" to "genuine social breakthrough." In general, the major emphasis on each program was the adaptation



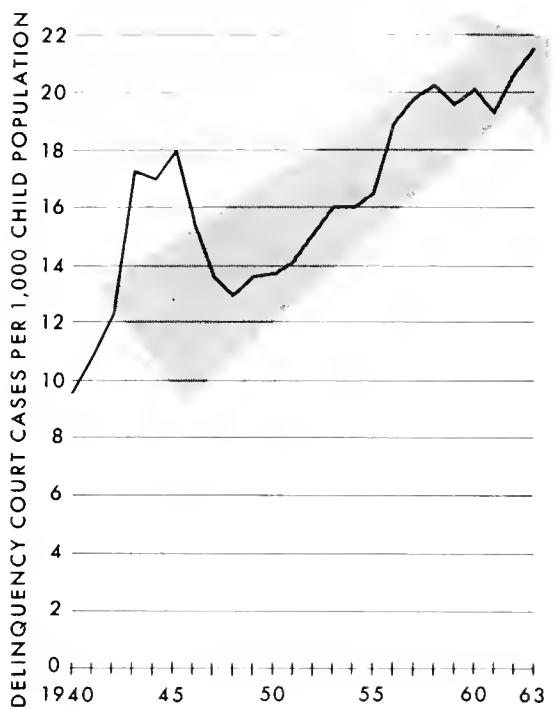
One of the outdoor reading classes in a camp sponsored by a community program for prevention of juvenile delinquency.

of school programs, work training and placement, welfare, correctional, health, and recreational services in order to open up new opportunities for achievement for socially deprived youngsters. Although practically all projects provided for some individualized services, the emphasis was on the use of individual social or psychological treatment to help youngsters get a better education and enter the labor market.

This emphasis on the provision of opportunities to all youth in areas where delinquency is high is in marked contrast to the 1960 White House Conference recommendations, which seem to be based on the assumption that delinquency prevention and control mean treatment of the individual delinquent. For example, a key White House Conference recommendation calls for expansion and coordination of "a full sequence of services, including referral, short term and long-term therapy, emergency services, rehabilitation, aftercare services, and research" (529).

Today, as a consequence of the PCJD program, such an exclusive emphasis on treatment would be viewed as naive. The emphasis has shifted from rearranging the delinquent, so that he will respond to society in a more acceptable way, to rearranging society. Specifically, the end sought is a school, a family, a job, and a health and welfare system that are responsive to the needs of the deprived and can reincorporate the social exile into the larger community. The emphasis has shifted from the effort to use a therapist to convert the lower class delinquent

RATES IN JUVENILE DELINQUENCY, 1940-63
Per Child Population Ages 10-17



to middle class values, to the creation of communities in which the value of full development of each human being is articulated in the structures of the community. The delinquent is no longer seen as merely in need of conversion to the value system of the larger community. The aim is to change the community's values and so secure changes in educational, health, and welfare systems to eliminate the social shutting-out that breeds delinquency.

The PCJD operated on the theory that the process of reincorporation necessitated the involvement of slum dwellers in the planning and management of the antidelinquency programs. Thus, to some extent, each demonstration project has sought to help the residents of the target area take action to improve their own social situation. Residents of such areas, it had been found, felt powerless in the face of bureaucratic authority. They lacked skills necessary to deal with representatives of social institutions in an effective, constructive manner. To help them gain such skills and a sense of themselves as participants in a democratic structure, the projects try, through the work of patient, sensitive, and skillful staff, to help them assess their social problems as citizens and work toward their solution.

If, for example, the residents of a remote rural community complain of lack of school transportation, the social worker may suggest that they meet together to discuss this need. When the meeting occurs the neighbors may, for the first time, realize their power as citizens and the possibilities it gives them for affecting bureaucratic decision-making. Even when the situation does not change, the people may. At worst, they will be disillusioned and frustrated. At best, they may gain the competence as participating citizens that guarantees social progress.

The 1960 White House Conference recommended that "in designing preventive programs, organizations listen to suggestions and recommendations made by delinquents themselves" (537). Few of the Conference participants could have anticipated the extent to which the helpers and the helped would enter into partnership in the years which followed.

Nor could they have anticipated the extent to which the helped would become helpers, for part of the effort to involve residents of target areas in the solution of their own problems has been their employment to help one another. One of the most successful elements in the Mobilization for Youth project, for example, has been in the use of more successful pupils in schools in deprived neighborhoods as tutors for less successful pupils. Still another has been the employment of women successful in home management to help neighbors who are less successful in this area.

The participants of the 1960 White House Conference seemed to accept the view, current at the time that the helpers needed full professional training and that the utilization of untrained personnel was an act of desperation. The Conference called for training of "pediatricians, obstetricians, teachers, ministers, lawyers, welfare workers, probation officers, school social workers, psychologists, as well as psychiatrists" for work with delinquents (525). The need for more persons in all these professions is still pronounced, but there is a growing appreciation of the contribution to the helping process of persons who have no degree but who do have native qualities and a life-style that places them *en rapport* with submerged groups.

Training Grants

In addition to the demonstration grants, the PCJD has given a number of training grants. However contrary to the recommendation of the Conference these grants have not followed "the current pattern . . . for the National Institute of Mental Health," since they have been made for short-term training only, as prescribed by the act. The effort has been

through workshops, institutes, and the like to provide the specialists with the extra training that might help them deal more successfully with delinquency.

To provide these training opportunities, 42 interdisciplinary training centers have been established with PCJD support. The emphasis has been on interdisciplinary training, because the knowledge needed by persons who work with delinquents can be called from a variety of professions.

The existence of the PCJD program has accentuated the critical shortage of persons trained in the helping professions, and the situation has been further aggravated by the launching of other significant national programs in the health and welfare field. The time is more than ripe for the full implementation of Conference recommendation 525, not only in the interest of delinquency prevention and control but also in the interest of the diverse but related national efforts to solve pressing social problems.

Evaluation and Research

As might be expected, the Conference, in a number of recommendations, called for additional research. It specifically recommended the development of predictive devices for early identification of the potential delinquent, expansion of knowledge about the causation of delinquency, and inquiry into the relationship between slow learning and delinquency. It also asked for improvement of statistical techniques and consultative services for the evaluation of community antidelinquency programs (546).

The PCJD program requires scientific evaluation of the demonstration effort. From such research there will undoubtedly emerge new knowledge concerning the causes of delinquency and the relationship of slow learning to these causes. More important, there will be substantial data on the effectiveness of different methods of dealing with delinquency.

The Conference recommendation concerning predictive devices, which came out of one workshop, was somewhat at variance with the recommendation of another workshop, which asked schools not to "label" children as vulnerable to delinquency "solely on the basis of prediction scales" (547). This paradox was the result of different points of view concerning the proposals of Sheldon and Eleanor Glueck of Harvard University, who have long been engaged in studies concerning delinquency and its prediction.³ Since 1960, the New York City Youth Board has completed its study of the Glueck prediction table and reports that there are valid predictors for discriminating at an early age between those children who are likely

to become delinquent and those who are not.⁴ This study, however, has already been subject to vigorous criticism.⁵ [See page 83.] Future use of such instruments will probably be determined partially by the treatment strategies employed and partially by the results of similar studies focused on children living under conditions different from those of the boys who were the subjects of the Youth Board study.

If the focus remains on adaptation of community institutions, then the impact is on all children in a neighborhood and discrimination concerning who is the most vulnerable is somewhat beside the point for treatment, but very important for the purpose of evaluating program impact. If, on the other hand, the focus shifts to tailor-made programs for vulnerable children, prediction becomes of paramount treatment importance. A validated prediction scale marks the youngsters likely to become delinquent unless there is successful intervention; they then become treatment targets. Further work on the Glueck prediction table by responsible researchers and practitioners may shed light on what type of intervention works with which "potential delinquent."

The Conference's recommendation regarding improved statistical techniques has received consistent attention from the Children's Bureau. With the assistance of the National Council of Juvenile Court Judges and others, the Bureau recently designed a "model" juvenile court statistical card which is to be the foundation of an improved local-state-Federal reporting plan. While the new plan is not yet in operation, the Bureau, under the auspices of the PCJD, has initiated another experimental plan through which it receives monthly reports from large-city courts providing information on reasons delinquency cases were referred to court and on their disposition—a type of data not collected in the current local-State-Federal annual reporting plan. The Bureau's continued annual statistical reports on juvenile delinquency show that, in 1961, delinquency court cases decreased (1 percent) from the previous year for the first time since 1948; in 1962, they again increased—by 10 percent; and in 1963 they increased by 8 percent.⁶

Rehabilitation Services

The Conference's concern with the treatment and rehabilitation of delinquent children and youth has been answered in part by stepped-up consultation services to communities provided by the Children's Bureau through its Division of Juvenile Delinquency Service, by the National Council on Crime and De-

linquency, and to a lesser degree by the PCJD program. The Conference especially stressed the need for improvement of police and court services, institutional care, and aftercare (542). Since police and court services, which are largely local in structure, have suffered for want of manpower and resources, the Conference looked to the development of State leadership to strengthen them (528A, 530). There has been some movement in this direction, but not of a substantial nature.

As a matter of fact, improvement in the services for the apprehended or adjudicated delinquent is steady but very slow. The PCJD until recently has given little attention to this aspect of delinquency control, and though leadership has been available through local, State, and national public and voluntary agencies, there has so far been no solution to the lack of money, manpower, and technical knowledge that inhibit full development. These fundamental lacks are complicated by the public attitude toward the apprehended or adjudicated delinquent, which is an amalgam of fear and hostility.

As the mid-point between White House Conferences arrives, the PCJD is turning its attention to demonstration-research projects concerned with a sharp focus on the delinquent himself. This shift in emphasis is due to the passage of the Economic Opportunity Act of 1964, which, in Title II, makes possible grants to local communities for community action programs⁷ very similar to the programs launched as antidelinquency demonstration projects under the Juvenile Delinquency and Youth Offenses Control Act of 1961. The Economic Opportunity Act was designed to provide the means whereby the poor may participate in programs to enable them to climb out of their poverty through job and school achievement—essentially the conception which undergirded the PCJD demonstration endeavors.

Evidence of this similarity is found in the degree to which communities are using experience gained in planning or conducting PCJD projects to design their antipoverty programs. Title II calls for the maximum involvement of the poor in planning and conducting programs, thus echoing a concern manifest in the PCJD program. As a matter of fact, the White House Conference recommendations concerning prevention of delinquency through youth conservation camps, resident schools, day-care facilities, and improved school facilities (527, 534) will be implemented, at least partially, by programs made possible under the Economic Opportunity Act.

The passage of the Economic Opportunity Act enables the PCJD to turn its attention to those young people most difficult to help, who may well escape the attention of the more massive programs. The Office of Juvenile Delinquency and Youth Development, which administers the PCJD program for DHEW, is now refocusing attention to the hard-core delinquent. Since the Office is now in the Welfare Administration, its program can be closely coordinated with the work of the Children's Bureau and the Bureau of Family Services.

With the Economic Opportunity Act providing new structures for the incorporation of deprived people into the benefits of the affluent society, the local, State, and national agencies specifically concerned with delinquency can tackle the difficult task of reincorporating the delinquent into such a society. Among the tasks that lie ahead are:

1. Insuring that programs aimed at increasing job and school achievement involve hard-core delinquent
2. Applying some of the advances in programs of instruction to the delinquent's education.
3. Altering the culture of the institutions for delinquents so that they can influence, and so change the value system of the delinquent.
4. Finding ways and means through which constructive plans for changes in existing health, welfare, and educational institutions can be evolved by those to whom these institutions belong and can be carried out to successful conclusions.

One can be certain that the 1970 White House Conference will find much that remains to be done. Enough has happened, however, in the first 5 years of the sixties to insure that the problems faced by the conferees in 1970 will be of a different order from those that preoccupied the work groups on delinquency in Washington, D.C., in 1960.

¹ Golden Anniversary White House Conference on Children and Youth: Recommendations—composite report of forum findings. National Committee for Children and Youth, Washington, D.C. 1960.

² Ohlin, Lloyd E.; Cloward, Richard A.: *Delinquency and opportunity*. The Free Press, Glencoe, Ill. 1960.

³ Glueck, Sheldon and Eleanor: *Unravelling juvenile delinquency*. Commonwealth Fund, New York. 1950.

⁴ Craig, Maude; Glick, Selma: Ten years' experience with the Glueck social prediction table. *Crime and Delinquency*, July 1963.

⁵ Citizens' Committee for Children of New York, Inc.: The status of the New York City Youth Board's delinquency prediction. (Mimeo graphed.) New York. 1965.

⁶ U.S. Department of Health, Education, and Welfare, Welfare Administration, Children's Bureau: *Juvenile court statistics—1963*. Statistics Series No. 79. 1965.

⁷ "The Economic Opportunity Act of 1964." *Children*, September-October 1964, page 198.

PERSPECTIVES IN YOUTH EMPLOYMENT

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ONE OF THE MAJOR contributions of the 1960 White House Conference on Children and Youth was to focus attention on the problems of adolescents and young adults in becoming contributing members of society. Several trends accounted for this concern—the effect on employment opportunities of the recession of 1958, the rapid rise in the skill level demanded for entry workers, and the fact that the high birth rate of the forties was going to produce a net increase of 26 million young workers in the decade of the sixties. In the ensuing 5 years, communities have designed a variety of programs to help those young people who are unable either to stay in school or find jobs.

In these efforts, communities have been assisted by various Federal programs—most notably the programs for work training under the Manpower Development and Training Act of 1962 and the growing emphasis in the U.S. Employment Service on helping local employment services provide special counseling and placement services for young people. So far, however, these programs have not been widespread enough to be regarded as anything but demonstrations. For example, while 100,000 training positions for youth have been created under MDTA since its inception, a large proportion of these have been made available only since November 1964, so that their effects cannot yet be measured. Similarly, while the U.S. Employment Service has plans for organizing 138 youth-opportunity centers in major metropolitan areas by July 1, 1965, only a half dozen of these are now in operation. And the mass efforts which will be generated under the Economic Opportunity Act of 1964 are only now getting under way.

Nevertheless, while the effects of a more massive approach to training, counseling, and placement ef-

forts cannot now be assessed, it is pertinent to look at some of the problems and dilemmas involved in efforts to help young people find a niche in society.

The Problem

Looking at recent trends in youth employment, it is clear that:

1. The national dropout rate is falling, and there is a steady increase in the proportion of youth enrolled in school. In 1963, for example, 93 percent of all youth 14 to 17 were in school, compared with 83 percent in 1950. Nevertheless, a 1963 sample of 16- to 21-year-old dropouts showed one-third had left school by the time they were 16.¹

2. Unemployment is higher among dropouts than among high school graduates, but the differential is decreasing.

3. In spite of an enormous economic upsurge in 1963 and 1964, there are still about 1 million unemployed youth between the ages of 16 and 24 who are not enrolled in school and who have not completed college. The overall unemployment rate for the out-of-school 16-24 age group has been between 11 to 12 percent ever since 1959.²

4. If one looks at various subgroupings in the youth population, the figures are more startling. For example, in February 1963, unemployment among nonwhites 16 to 21 was 25.8 percent, compared with 18.6 percent for this age group as a whole.³ The differential between nonwhites and whites is, of course, even greater.

Data on specific age, sex, and ethnic groupings in the labor force tend to show that while the economy has been able to absorb a certain number of youth at all skill levels, the residual has not grown smaller; entry jobs have increased neither as rapidly as the

population nor as the Nation's economic growth.

Concern for youth in their work role impinges on all the social science disciplines, both in theory and in practice. A leading child psychiatrist, Dr. Leon Eisenberg, for example, has said:

It cannot be too highly emphasized that the psychological basis for a sense of individual worth as an adult rests upon the acquisition of competence in a work role during the stage of adolescence. A sense of competence is not required on the basis of "reassurance" but rather upon the actual experience of succeeding in a socially important task.³

Many anthropologists and sociologists are concerned about the development of a so-called "youth culture," in which young people tend to substitute peer group norms for adherence to values of the larger society. They point out that this kind of youth culture, alien to most adult standards, seems to develop as a response to lengthened dependency. Whether or not the group adhering to it is delinquent, it offers a spurious identity in lieu of opportunity for constructive social participation.

Apart from economic considerations, the inability of the adult society to plan for the meaningful participation of youth makes the burden of maturation more difficult and prolongs the process, often to unbearable lengths. It is significant that at age 24 the unemployment rate among young workers becomes the same as the overall rate. Thus young people seem to have to "age" into the labor force. Until they do this, they have little opportunity to make their contribution to the economy. And in most communities, few other opportunities to participate constructively in the society of adults are open.

Dr. Eisenberg also has pointed out that—

At a psychological level, the most striking attainment during the adolescent period is the ability to conceptualize at an abstract level. . . . It is this capacity for abstract thought that accounts for the increasing concern of the adolescent, on the one hand, with problems at a national and international level and, on the other, with the basic meanings and values of human existence.³

A society that does not utilize this quality, often manifested in "idealism," deprives itself of a highly significant contribution that youth can make.

This is a concern that goes beyond poverty and beyond the job problems of the "slow learner" or the dropout, involving as it does not only the question of opportunities for employment but also for service to society in other ways. It is, nevertheless, related to the preoccupations of the delinquency specialist, the educator, and the manpower specialist.

Unfortunately, when actual program is undertaken, the notion of meaningful participation tends to be watered down to the provision of "work experience." There is a commonly accepted idea that remunerative employment of *any* kind can bridge the gap and bring the motivations and aspirations of deprived youth into line with the rest of society. This idea has not met with notable success in practice, possibly because the kinds of opportunities available have not served to develop individuals either in terms of social participation or of occupational training.⁴ The Neighborhood Youth Corps now being established under the Economic Opportunity Act to provide paid jobs in public or voluntary agencies to a large number of youth, should furnish an adequate test of the developmental value of short-term work experience under a variety of conditions.

Program Complexity

Placement. Not all program development involves this kind of simplification. In fact, sophistication in design has increased enormously.⁵ Not so long ago almost all community approaches to youth employment were initiated on the assumption that placement in a job was the critical service need. This assumption has some basis in fact.

The most common way to get a job in the United States is through personal contact or direct application to a known source of employment. The availability of such contacts and information depends on the milieu of the individual. Youth who are members of severely deprived families not only lack role models of workers, but also are cut off from access to the kinds of specific vocational help available to children of stable working-class or middle-class families. Placement service, therefore, seems to be the logical substitute for familial intervention.

Unfortunately, however, placement service is not always an adequate substitute for personal influence. Families who will add a relative to a marginal small business will not take on a stranger; and the recommendation of an employment service, no matter how well grounded, is often not as effective as an introduction from a neighbor. Placement service can perform two important functions—it can make a better match between the individual and his job, and it can reduce the time between jobs. At any level less than full employment, however, entry level jobs for high school graduates and dropouts tend to be filled by young people who have some direct access to the job.

The intervention afforded by placement service can be of help in finding employment for youth who

lack such access. But the number of placements reported in a given program is seldom a reliable guide to its success; there is no way of telling how many placements have been in casual employment, characterized by short duration or high turnover.

Counseling. Whatever the success of placement attempts, there is almost always a residual group for whom no job of any kind can be found. In this group are young people with serious problems of health or behavior. Others, however, who are willing and able to work, can find no place under current labor market conditions. No one knows for certain the relative number of these two quite different types, but the tendency of program designers is to treat them all as if they were "unemployable." When the problem is viewed in this way, the natural tendency is to cast about for ways to make the "unemployable" employable, and the resulting programs are essentially rehabilitative.

General Preparation for Work. As youth employment programs have developed in recent years, the two chief elements have been work experience and counseling, although in forms significantly different from those used in the past.

Traditional vocational counseling is not always appropriate in dealing with disadvantaged youth. As a technique, it is designed to help individuals make realistic choices, assuming, of course, that there are alternatives. Given present job requirements and testing procedures, many young people, especially those whose aptitudes and interests have remained unstimulated, find it hard to see why they should engage in discussion geared to choices they do not have. Counseling in new programs, therefore, has taken on a conditioning pattern in which individuals or groups are exposed to facts about the job market, the need for punctuality and industriousness, and requirements of neatness and good grooming.

Work experience provided for youth traditionally has been related to apprenticeship, in the sense that some kinds of training can most usefully be acquired on the job. Both colleges and secondary schools have used such vocationally oriented work experience for many years as an integral part of curriculum. In youth employment programs, however, work experience has a somewhat different purpose. Here it is not geared to acquisition of specific skills, but, in much the same manner as counseling, to conditioning—on the theory that exposure to the demands of any kind of work will have a beneficial effect on work habits and attitudes.



An instructor works with his group of students, in a training center for youth in Kanawha County, West Virginia.

We have called this combination of elements "general preparation for employment," since it is designed as a bridge to the labor market in general, rather than to specific kinds of occupations. Starting with the Detroit Job Upgrading Program in the forties, general preparation programs have grown in number. Sometimes tryout shops have been substituted for work experience, and there have been experiments with counseling techniques, but the combination of some kind of individual counseling or group guidance and of one or another form of work experience is always included.

Occupational Training. Yet another step in program development has been the addition of a skill-training component. Basically, those who have advocated this tactic or put it into practice have proceeded on the assumption that mere good will and amenability are not enough, and that the unemployed need something to sell employers.

The problems in organizing short-term training programs are many, and the rewards have not been great. Many recognized occupations have standard training pathways. Others do not actually require training. In between are a number of occupations on which disagreement about requirements is so great that the fulfillment of the program does not necessarily accredit the young worker.

The original provisions of the Manpower Development and Training Act of 1962 tended to screen out severely disadvantaged youth, but later amendments extended the benefits to reach more of them.

. . . The eligibility age was lowered from 19 to 17, the weekly allowance for most youth in training was raised to \$20, and administrators of programs were informed that 25 percent

of all persons receiving training allowances could be youth under age 22. . . .

The main reason for these amendments was to permit new and special programs for those youth with inadequate education to qualify for regular MDTA training. It made it possible for young trainees to draw training allowances for an additional 20 weeks for "the development of the basic educational skills."⁶

Special youth programs developed under the new regulations:

". . . shall include guidance, counseling, testing, and occupational training, and may include basic education, social adjustment, job development, placement and follow-up services and other instruction or special services tailored to meet the needs of individual youths."

Since then 59 such "special youth projects" have been approved by the Department of Labor. They will train nearly 30,000 youths in a variety of occupations, for an estimated cost of \$47 million. Thus far, 11,630 young persons have enrolled in the special programs and 7,541 of them have been given instruction in basic education. Nearly 2,000 have already completed their schooling, and of these, 1,004 have gotten jobs.⁷

Experience shows that the new special programs are reaching more disadvantaged youth than the regular MDTA training. For example, 35 percent had 12 years of schooling, compared with 60 percent in regular projects. Most of these projects have not been in operation long enough for published results, so that judgment about the longer range effects on the trainees must await careful followup and evaluation.

A few training programs, paid for by employers, on the model developed by companies in Chicago and now getting under way in Newark, N.J., have employed disadvantaged youth and offered them training both on the job and in the classroom. They include large department stores, utilities, financial institutions, and large manufacturers with service operations. This is a clearly superior adaptation, since the job itself becomes part of the present rather than of some nebulous future. The growth of this type of program has been slow; there are probably under 1,000 youth involved all over the country.

The Youth Development Focus. In a few cases, programs, by combining all possible elements, have sought to insure that a youth will reach his maximum potential. Focusing on individual deficits, they offer remediation in basic educational subjects, occupational training, work experience, counseling, and placement services. Often these are truly innovative in their approach to the target populations, in the introduction of such new techniques as programed instruction for the teaching of technical subjects, or in the use of some of the techniques of vocational rehabilitation such as the sheltered workshop.

For example, the newly created Job Corps, under the Economic Opportunity Act, is adding to existing innovations the concept of the residential center. Just as the Neighborhood Youth Corps will afford a massive test of work experience, the Job Corps—under which youths in camps and urban residential centers are given work experience, training, and educational opportunities—provides an opportunity to see what a wholly new institutional form will add to the stock of program possibilities.

Unfortunately, the search for new program ideas sometimes becomes an end in itself. The paradox is that the more successful the rehabilitative techniques employed, and the more individuals are not only persuaded but trained to work, the more necessary it is to have actual jobs available in which to place them. And under the present pace of technological change, the jobs available today may not be those available tomorrow.

The best placement experience of recent employment services for youth has been from 20 to 30 percent of registration. Of course, the more restrictive the selection, the higher the placement rate; but where undifferentiated populations of unemployed youth are recruited, the results are far from encouraging.⁷ Limited numbers of youth can be placed at great cost in time and effort, particularly if the job developers are not too concerned about the future of the job or the potential of the youngster. But a program may make a youth "employable" without necessarily finding him employment. Rehabilitative programs are most beneficial when directed at developing special kinds of manpower in short supply.

To some extent, this fact accounts for much of the current emphasis on increasing the national supply of college graduates and professionals. The most obvious shortages are in the higher level occupations, but even where the demand for such trained personnel can be made economically effective, the time necessary to produce them is considerable. It is perfectly possible to agree that increasing the general educational level of the population is the most urgent long-term goal, but there is little hope in the short run of materially affecting the prospects of unemployed out-of-school youth with such a strategy.

It is often alleged that vacancies also exist in certain low-level service occupations. To the extent that such shortages are real, the problem is clearly not connected with training, since the skills required of a hospital aide, for example, can be learned in a relatively brief period on the job. The trouble lies

in the way work is organized, in marginal pay scales, and in the obvious dead-end quality of the position. That the most menial work is highly prized when these problems are dealt with can be seen in the case of municipal sanitation departments where garbage collectors are relatively well-paid and have the security afforded by civil service and opportunity for upgrading to administrative positions within the department. The difference in how the question is characterized is illustrated by August Heckscher's contrast of the view of the man who—

... says in effect, that there cannot be any real problem of unemployment because his wife cannot get a cook, or because his hedges go untrimmed for want of a gardener. . . .

with the question of—

... why these needs are not satisfied and how we can organize the economic system so as to make it more responsive to what men and women require for their pleasures, their conveniences, their comforts and their spiritual delights.⁸

Where Will Jobs Come From?

Mr. Heckscher's reflections imply that ways must be found to create both new jobs and the opportunity for different kinds of people to participate in the labor force. For these purposes, it is necessary to investigate the possibilities of redesigning existing jobs and the expansion of manpower demand based on estimates of needed goods and services in addition to those now being produced.

Hiring Standards. There is some question as to whether present standards of screening and hiring in industry are based on efficiency, or whether they merely reflect the possibilities of "creaming" that a surplus labor market provides. For example, in suggested training programs for a series of service occupations, prepared by McGraw Hill, Inc., under contract with the U.S. Office of Education, it is recommended that candidates for the following occupations be high school graduates: clothing maintenance specialist, family dinner service specialist, landscape aide, and forestry aide.⁹

Involved in the issue of job qualifications, too, is the question of what people filling specific jobs actually do. Many professionals, for example, in fields like teaching, social work, and even engineering, spend a great deal of time on routine clerical or drafting tasks that could be separated from their function with obvious gains in efficient use of personnel.

Some economists are concerned with alleged low productivity in occupations providing community and personal services, particularly since it is only in the non-goods-producing sectors of the economy that

employment has been increasing.¹⁰ But in the field of services, it is not at all clear that the addition of more personnel necessarily lowers productivity. On the contrary, it might free better trained people—professionals in extremely short supply—to perform more difficult functions. With nurses as supervisors and administrators, it is possible to improve hospital service through the employment of aides and orderlies. With social caseworkers involved in therapeutic processes, someone most likely at a lesser level of training should be available to make home and collateral visits and act as a bridge between community services and their clients.

Instances of this kind can be multiplied. What is involved is the building of new career lines to engage the energies of many potential workers who now have no opportunity to contribute to the larger society. Some experimentation is going on along these lines today in the teaching, nursing, and social work fields, but a great deal more needs to be done. Perhaps the experience gained by health, welfare, and educational agencies, in providing youth with service opportunities through participating in the work-study programs of the Neighborhood Youth Corps, will provide some directional signals to the kinds of jobs that can be created which will simultaneously alleviate pressure on perennially scarce professional personnel and open career doors to young people.

Job Creation. There is a school of thought exemplified by Robert Theobald and the members of the Ad Hoc Committee for the Triple Revolution, who are ready to abandon the search for employment opportunity on the grounds that automation is destroying jobs faster than they can be created. Such despair seems premature when so many unfinished tasks abound on the national and international scenes.

Planning for the accomplishment of these tasks, and the new ones that constantly arise, requires the making of estimates on the rate of expansion of the economy as a whole, and on its separate parts. Such estimates have been made for several sectors of the economy by private and quasi-official groups.^{11, 12} But manpower planning is still in its infancy as a conscious instrument of public policy. In fact, in both the public and private sectors, efforts are constantly being made to economize by keeping the numbers of the employed at a minimum.

In some quarters, the unemployed have been written off as permanently unemployable. Their failure to find jobs is attributed to their own problems, in spite of the fact that little attention is paid to roles

they might perform in the expansion of existing forms of construction, production, transportation, and services, and in the host of innovations to come. In the area of human services, Eli Ginzberg has put the challenge this way:

... Really imaginative planning would seek to enlist many of the disadvantaged, who themselves need work, in programs that could contribute significantly to the range of services that children and adolescents from these same groups require if they are to be properly prepared for work and life.¹³

Programs in many parts of the country are utilizing this concept. The provision of the Economic Opportunity Act that programs be developed, conducted, and administered with maximum feasible participation of the low-income target population has stimulated the design of nonprofessional components in the majority of projects being funded under Title II (Community Action Programs). The experience gained in these efforts will have important long-run effects on manpower planning in the human services and may also indicate new directions for hiring practices in other fields.

The same kind of "astute planning" in all sectors would provide guidelines as to needed training programs, gaps in service, and a truer picture of the occupational future of the American people. In the economic upturn of the last 2 years, we have seen that even high rates of profit and growth are not alone sufficient to create the number of jobs needed, although they may be essential as a base for further development. For encouraging youth to assume an appropriate role in society, more is required than efforts to ease the transition from school to work. Both these major institutions have to be altered in ways that will enhance their significance to those now cut off from making their own contribution.

The efforts now being made to improve the quality of education must be extended to average students and to those who now lack high academic interest. This goal has long been on the agenda of the public education system, but in too many places basic problems of school finance and overcrowding have pushed the question of quality education into the background. With growing national concern, educators may be freed to concentrate on content and on the climate of the schools, with the aim of raising the educational level of the population as a whole.

It would be an enormous oversimplification, however, to lean altogether on the schools as a solution to the problems of work and employment. As already

indicated, the creation of useful jobs at rates of pay high enough to live in health and decency is a necessary first step.

It is probably true that a significant number of people now at work would prefer to leave the labor force, and would do so if the family could be assured an adequate living. Such questions remain speculative, however, until we reach the actual limit of employment under changed conditions of demand

We are only beginning to experiment, for example with the lowering of certain hiring requirements and the widespread use of nonprofessionals. And we have not yet begun to use our national imagination to invent ways to provide those public and private services needed to enhance the quality of our daily lives. Until our infant mortality rate is the lowest in the world (we rank 10th among nations), until our aging citizens live in dignity, until our housing and our physical conditions begin to approach level now considered utopian—until these and other items on the national agenda are dealt with—we cannot really know the limits of demand for the work of people. Only by testing these limits can we plan for the fulfillment of our national aspirations.

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⁵ Benjamin, Judith G.; Lesh, Seymour; Freedman, Marcia K.: Youth employment programs in perspective. U.S. Department of Health Education, and Welfare, Welfare Administration, Office of Juvenile Delinquency and Youth Development. In press.

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⁷ Cloward, Richard A.; Ontell, Robert: Our illusions about training. *American Child*, January 1965.

⁸ Heckscher, August: Reflections on the manpower revolution. *American Scholar*, Autumn 1964.

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¹² Albee, George W.: Mental health manpower trends: report of the Joint Commission on Mental Illness and Mental Health. Basic Books: New York. 1959.

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HERE AND THERE

Against Poverty

As of mid-February, the Office of Economic Opportunity had completed plans for nearly 400 separate "War on Poverty" projects, totaling over \$221 million in estimated costs, under the revisions of the Economic Opportunity Act of 1964. (See *Children*, September-October 1964, page 198.)

Plans for six urban *Job Corps* centers had been completed—at Camp Kilmer, N.J.; Tongue Point Naval Station, Ore.; Camp Gary, Tex.; Camp Parks, Calif.; Camp Atterbury, Ind.; Camp Breckenridge, Ky. Arrangements had been made with educational institutions and business corporations to provide training in a variety of skills to their residents—unemployed, out-of-school youth age 16 through 21. Each center will train 1,250 to 2,500 youth. Separate centers for girls will be established.

Arrangements had also been made for 62 rural *Job Corps* conservation centers in 28 States; with 87 centers the goal for 1965, at a construction-and-operation cost of \$46 million. In these conservation centers, 100 to 200 young men, 16 through 21, will work in conservation tasks while receiving basic education and instruction in job skills. The rural centers will be operated by the U.S. Departments of Agriculture and Interior.

As of mid-February, more than 100,000 applications for *Job Corps* placement had been received by the Office of Economic Opportunity.

The maximum *Job Corps* tour is 2 years. It is estimated that over 40,000 young people will be enrolled in the *Job Corps* in the first year of operation. More than 30 national organizations have agreed to recruit for the Corps at their own expense.

In the *Neighborhood Youth Corps* work-training program for unemployed youth and youth attending school, administered by the Secretary of Labor, 9 projects in 27 States, to cost about \$8 million, had been approved by mid-February. In addition, \$20 million worth of projects are being planned to provide part- and full-time employment

for 50,000 high school youths next summer, to enable them to earn enough money to return to school in the fall. They will work for public or nonprofit organizations as laboratory aides, tutors, water supply conservationists, X-ray technician aides, receptionists, clerical aides, teacher aides, nurses' aides, library aides, playground aides, park ranger aides, forestry aides, and other tasks.

It is estimated that between 125,000 and 150,000 young men and women will be enrolled in the *Neighborhood Youth Corps* program during 1965. They will be paid \$1.25 an hour for work performed.

More than 700 universities and colleges had filed applications with the U.S. Office of Education for support for *work-study* programs; 577 of these applications had been approved. The first grants will bring part-time employment to nearly 35,000 college students.

More than \$28 million in Federal *community action* grants had been approved to provide financial support for 150 community action programs in urban and rural areas. Stimulated by the opportunities in the act, 90 percent of U.S. cities with populations of more than 50,000 (including nearly all of the 219 standard metropolitan areas in the Nation) and over 160 rural areas (including Indian reservations) had, by mid-February, formed local antipoverty organizations.

Grants had so far been made to 29 States, 60 cities, 25 rural communities, 6 universities, and 3 Indian tribes. These grants will support local community action programs already underway, and will also be used to plan and operate new programs.

One grant was made to the North Carolina Fund for recruiting and training college graduates and adults to work as community aid technicians for social agencies and in institutions, schools, clinics, and settlement houses.

The projects range from training non-professional technicians for working among poverty-stricken people in North Carolina to a broad \$3.9 million multi-faceted program in Chicago, the largest

of the community action grants to date. The funds will be used for remedial education and job training in isolated rural areas, studies in improving employment opportunities, preschool training to help children in impoverished areas adjust to classroom environment, multipurpose neighborhood centers in the slums of an industrial city, library service, recreational facilities, health education, home management counseling, and, in at least one instance, for a mobile planned parenthood clinic.

In addition, \$150 million in community action funds had been earmarked for Project Headstart, a preschool program in three phases for children in low-income areas. Of this, \$15 million had been earmarked for an 8-week summer program in community-operated centers to provide preschool education for 100,000 children going into kindergarten or first grade next fall; 4- and 5-year-olds from disadvantaged families in 200 to 300 communities. The second phase will consist of a followup on the children who participated in the first phase, and the third phase will be the development of fully comprehensive programs for early-childhood education, 9 months to a year in length. Plans are to extend the program through the remainder of fiscal 1966, to reach 300,000 additional children. The children will be given medical checkups; glasses, if needed; high nutritional meals; as well as stimulation and instruction in the use of language and other basic skills.

About \$19 million had been earmarked for the *adult basic education* program. During fiscal year 1965, basic schooling will be provided for 37,500 adults. Courses are open to persons 18 years old or older who have not completed elementary school, or whose inability to get and hold a job is caused by lack of education.

Approval for 30 *work-training projects for unemployed fathers* had been received from the Welfare Administration, to cost over \$21 million, almost all of which is funded in full by the Federal Government. The projects will provide work experience and training for approximately 33,000 participants with about 95,000 dependents, most of whom will come from families receiving support under the Federal-State program of aid to families with dependent children.

Projects had been approved in seven-

teen States—Alaska, Arkansas (with two projects), California (eight), Georgia, Iowa, Kentucky, Louisiana (three), Maryland, Massachusetts, Minnesota, New Mexico, North Carolina, Ohio (two), Pennsylvania, Rhode Island, Utah, Wisconsin—and Puerto Rico and the Virgin Islands.

As of mid-February, 49 *VISTA* projects (*Volunteers in Service to America*) had been approved for 20 States. For these, 239 trained volunteers will be dispatched to the mountain communities of Appalachia, to migrant workers in Texas, to the slums of New York City and Miami, and to Indian reservations in Arizona, Minnesota, North Dakota, South Dakota, and Utah.

Volunteers will work in rural and urban community action programs, in Job Corps camps, and in hospitals, schools, and institutions for the mentally retarded. Their assignments will range from helping slow learners in school and initiating self-help housing projects to giving counseling and vocational training to teenagers and operating day-care centers. The first *VISTA* volunteers trained at Camp New Hope, N.C.

—Charles Cooke

Teenagers

The 1947 baby crop, part of the post-war baby boom, resulted in 3,700,000 American young people reaching their 17th birthday in 1964, according to a recent analysis of Bureau of the Census figures made by the Population Reference Bureau, a nonprofit research and educational organization in Washington, D.C. This was 800,000 more than the number who reached 17 in 1960.

The report of the analysis, released as a "Population Profile," points out that if 1960 percentages held true, of these 3,700,000 youngsters who became 17 in 1964:

- One-fourth had already dropped out of school; 4 percent were still in elementary school; and 3 percent were already in college.

- About 258,000 were already married—12 percent of the girls and 2 percent of the boys.

- About one-third of the boys—630,000—would be found unqualified for military service if examined for induction at age 18.

The report indicates that there will be a slight decline in new 17-year-olds in 1965 and 1966, but an increase in

each succeeding year, with the number reaching 4 million by 1974. It points out that this is part of a massive population growth of persons 17 years of age or under, a group which in the past 4 years has been increasing at 2 percent a year, and which in 1964 came to 70 million young people, or 63 percent more than in 1947, the year the 1964 teenagers were born. It predicts that high school enrollment will increase by 30 percent in the next decade and that, "even though the percentage of problem teenagers is not increasing . . . social, moral, educational, juvenile delinquency, and employment problems will increase each year."

Child Care

Child-care agencies under Jewish auspices are increasingly turning to the development of specialized residential treatment facilities and group foster homes and less to the use of regular foster family homes in their services to disturbed children, according to a recently issued report of the Council of Jewish Federations and Welfare Funds, Inc. The report attributes this development not only to an increasing difficulty of finding foster family homes, but also—and chiefly—to a growing realization of the destructiveness to children of replacement from one foster family to another. It points out that many children cannot be contained in foster homes, either because the problems they present are beyond the capacity of the usual foster parents to deal with or because they cannot tolerate the closeness of a foster family.

Other trends among Jewish children's agencies pointed out in the report are the coordination of existing services through mergers or the development of a central intake, and the search for "governmental, third-party, and other sources of financing." ("Current Directions in Jewish Child Care Services," an issue of *Council Reports*, Council of Jewish Federations and Welfare Funds, Inc., 729 Seventh Avenue, New York, 10019. 40 cents. Mimeographed.)

Since the initiation of a volunteer case-aide program in 1962, the Jewish Family Service of Worcester, Mass., has used 26 volunteers in direct services to families, according to Burton S. Rubin, executive director of the Jewish Family Service of Worcester. While the volunteers make no professional de-

cisions, they assist the caseworker in treatment by developing warm, friendly relationships with persons especially in need of them—a frightened, anxious adolescent returning from a State hospital, or a withdrawn, overwhelmed mother too disturbed and preoccupied to make friends—and helping them to find ways to participate in community life. The agency has found that many distraught, lonely persons who have been unresponsive to casework treatment alone have responded when consistent personal interest has been offered them from a warm person from the community.

The agency also uses volunteers in service to specific clients through case committee whose members are active in securing needed treatment resources—special foster homes and homemakers, and employment for disturbed teenagers and others unable to obtain work through the usual community resources. All the agency volunteer activities are carried on under the supervision of professional staff.

Parent Education

Forty-two persons with experience as practitioners or administrators in providing education in child care and home management to low-income parents met in Washington, D.C., for three days early last December to provide consultation to the Subcommittee on Parent and Family Life Education of the Interdepartmental Committee on Children and Youth, which is planning a publication on the subject. They came from 19 States and the District of Columbia and represented a variety of disciplines, including education, nursing, pediatrics, home economics, social work, human relations, child development, and psychiatry.

The projects they described were sponsored by agricultural extension programs, settlement houses, community YWCA's, health and welfare councils, local public welfare departments, hospitals, well-baby clinics, public health departments, mental health departments, planned parenthood clinics, public schools, day-care centers, universities, public housing developments, and a child development research institute. As described, the projects were experimenting with adapting the traditional forms of parent education to meet the needs of poor and poorly educated families of

ariety of races and cultures - Caucasian, Negro, American Indian, Puerto Rican, and Mexican. In most of them, the emphasis was on recognizing the cultural values of the groups served and using these as a basis for helping parents provide a physically and emotionally healthier home life for their children.

At the meeting, this recognition of differences in cultural values was pointed up as being of critical importance in efforts to reach and maintain the interest of those mothers and others most in need of parent education. While the emphasis was chiefly on mothers, a number of participants stressed the importance—and greater difficulty—of reaching and maintaining the interest of fathers.

Among other points, the participants emphasized—

In re ways of reaching and holding parents: the importance of face-to-face contacts in recruitment, informality and flexibility in arrangements and structure, building the initial program around immediate needs such as ways of using surplus foods, allowing mothers to bring their children and friends, giving each member a small fixed responsibility, and providing a warm, sensitive leader.

In re content and methods: the importance of setting specific goals, beginning with where people are but moving on from there; using methods calculated to increase the parents' capacity for decision-making; seizing the "teachable moment"; encouraging the group to set a specific project for completion at a specific time; involving outside specialists in the group participation.

In re the development of indigenous leadership: the importance of being aware of the existing leadership in the neighborhood as well as in the group; recognizing the possibility that hostility in a deprived person may be a sign of strength; of being aware of both the pitfalls and strengths of using neighborhood persons as group leaders.

In re suitable educational materials: the usefulness of a variety of materials—films, illustrated pamphlets, tunnel boards, puppets, playlets, tape recordings, and field trips; the importance of pretesting materials on the kinds of populations for which they are intended; the need for developing material on specific subjects, such as preparing the child for school, how to pre-

pare for a job, helping a child to succeed in school, how to keep children out of trouble.

In re research: the importance of devising simple evaluative materials for use in testing the effectiveness of a program; and the importance of basic research into the kinds of intervention most likely to bring about change.

Against Delinquency

Early in January, the Citizens' Committee for Children of New York, a non-profit voluntary organization concerned with the welfare of children, challenged as "questionable" recent New York City Youth Board claims of success in a 12-year experiment in the use of delinquency prediction tables, originally developed by Sheldon and Eleanor Glueck, and warned that the use of such tables may be harmful to children.

On the basis of a report prepared by its consultant, Alfred J. Kahn of the Columbia University School of Social Work, the committee charged that the efficiency of a delinquency prediction scale, offered in the Board's recently released "Manual of Procedures" for using delinquency prediction tables, had not been validated.

In the report, Dr. Kahn maintained that nobody knows whether predictions of potential delinquency protect the community or harm the child, since the research done on prediction scales "has not actually determined whether a scale of this kind can be used by any except highly skilled research staff or applied within schools or social agencies without serious damage to the children predicted for delinquency," or without affecting the objectivity of personnel toward a child labeled as predelinquent. He maintained that the scale offered in the Youth Board manual, having been designed to fit a specific group, "may be able to predict backward," but has not been tested in *forward* prediction. It is not the one with which the Youth Board began its studies 12 years ago.

Dr. Kahn cited a "crucial table" in the Youth Board report which showed that, of 44 boys in the Youth Board study who became delinquents, the scale missed 16 and predicted 28, and he questioned whether the same proportion of boys headed for trouble might not have been otherwise discovered without the expenditure and risks involved in the use of prediction scales.

He also pointed out that delinquency was not the sole problem affecting the boys studied, since the Youth Board report showed that 22 percent of the non-delinquent boys had problems in adjustment and therefore were also in need of early identification and service.

Dr. Kahn suggests that "prediction studies are important as a test of causal theories" when they are based on the premise that "all prediction is aetiological, dealing with rates within groups, not individuals."

"Predictions about individuals," he pointed out, "are not only inaccurate, but also run the risk of the self-fulfilling prophecy in relation to a phenomenon such as delinquency, which involves large components of social stigma and self-image. In addition, new services for youth may be more effective if addressed to 'young people' than if shaped for those considered 'pre-delinquent.'"

Unmarried Mothers

A preliminary survey "to explore the nature of repetitive out-of-wedlock childbearing within the AFDC [aid to families with dependent children] program" was recently completed by Dr. Kermit T. Wiltse and Robert W. Roberts of the School of Social Welfare, University of California, Berkeley. Sponsored by the California State Department of Social Welfare, the Contra Costa County (Calif.) Social Service Department, and the University of California, the area surveyed was in the western part of Contra Costa County, including the cities of Richmond, El Cerrito, San Pablo, and smaller towns—an area into which a large percentage of the population had migrated from the South.

The investigators reviewed case records, in the county's Social Service Department, of 997 women receiving AFDC who had borne children out of wedlock—almost half (47 percent) of the total AFDC caseload in the area under study. The 997 cases were divided into 4 categories: mothers who had borne one child out of wedlock (498), two (225), three (135), and four or more (139). Twenty-five percent of the case records in the first group were read; 50 percent of those in the second and third; and 100 percent of those in the "four or more" group.

Nearly two-thirds of these unmarried mothers had been married at some time in their lives, indicating, according to

the investigators, that the bearers of out-of-wedlock children "are not set apart as a group who never marry."

The majority of the mothers studied were born outside of California, and, on the average, had resided at least 5 years in California before receiving aid. This finding supported the theory that "people do not typically migrate in order to qualify for public assistance." It was found, furthermore, that the percentage of the mothers born out of the State increased with each increase of out-of-wedlock children born to them. And the mothers who had had only one out-of-wedlock child came on aid "at a somewhat younger age" than those who had had more than one, which suggested that those mothers who might be singled out by critics of the AFDC program as "career unmarried mothers on AFDC" actually came on aid at a later age than those who had had only one out-of-wedlock child.

Based on an analysis of the relationship of the mother with the father of

each child, the investigators concluded that these mothers "typically invested themselves in each relationship and that truly casual relationships [resulting in out-of-wedlock children] were rare"—in fact, only 2.6 percent.

In summing up, the investigators concluded that their data, "far from 'explaining' illegitimacy . . . may demonstrate the folly of pat explanations and give us a glimpse [of] the distance we must travel before we can speak of understanding so complex a social phenomenon."

The survey will be included in a book, "The Unwed Mother," edited by Mr. Roberts, to be published next year.

Miscellaneous

Since 1960 the schools of the United States have shown a steady increase in "holding power," according to a report of the National Education Association. National rates are up 1.6 percent. For the large city school systems, holding power has increased 2.5 percent

since 1961. Large city schools, however, have a higher proportion of "droouts" than those in small areas. The "holding power rate" is based on number of pupils who entered grade in one year and the number who graduated 3 years later.

The report, "Holding Power/Large City School Systems," can be obtained from the National Education Association, Washington, D.C., 20036. (\$2.)

"To Temper the Wind," a 30-min drama interpreting the values of homemaker service, is now available in printed form, together with acting directions and a discussion guide, from the National Council for Homemaker Services. The play was written and produced for the Council by Plays Living Division, Family Service Association of America. Copies can be ordered at \$2 each, and \$12 for a production kit of six, from the National Council for Homemaker Services, 17 Broadway, New York, N.Y., 10019.

Films on Child Life

Films listed here have been reviewed by staff members of the Children's Bureau. The listing does not constitute endorsement of a film, but indicates that its contents have merit. Charges for rental or purchase, not given because they change, may be obtained from distributors.

REPORT ON DOWN'S SYNDROME (MONGOLISM). 20 minutes; sound; color; borrow, rent, or purchase.

This film shows the development of two Mongoloid children over a 6-year period, stressing the importance of early diagnosis to (1) insure proper medical care; and (2) help parents develop the attitudes essential to the attainment by such children of their maximum potential. It also illustrates the general characteristics and treatment of the syndrome, including genetic findings and methods of chromosome analysis.

Audience: Parents, public groups interested in mental health; classes in all branches of medicine, in nursing, psychology, social work, nutrition; educators, public health, welfare, and rehabilitation personnel; clergymen.

Produced by: International Film Bu-

reau, with the cooperation of the University of Southern California School of Medicine and the Los Angeles Childrens Hospital.

Distributed by: International Film Bureau, 332 South Michigan Avenue, Chicago, Ill., 60604 (to purchase); local State mental health authority or film library, to borrow or rent.

VLANDALISM: CRIME OR PRANK? 5 minutes, 40 seconds; color; sound; purchase.

Designed to stimulate discussion, this film depicts a situation in which an adult sees a group of boys destroying public property and recognizes one as the son of friends. It presents two conflicting points of view: (1) that the vandalism was a boyish prank which should be ignored; (2) that the witness

has an obligation to report it, either to the police or to the boy's parents.

Audience: Junior high and high school students; parents; PTA, counseling, and youth-serving groups; other interested adults.

Produced by: Horizon Film Productions.

Distributed by: International Film Bureau, 332 South Michigan Avenue, Chicago, Ill., 60604. In Canada: Educational Film Distributors, Ltd., 5 Jarvis Street, Toronto 5.

WORLD OF A GIRL. 19 minutes; color; sound; loan.

Using the tape-recorded comments made informally by young girls about their attitude toward menstruation at its onset, this film is designed to introduce teenage girls to the subject of menstrual hygiene and adolescent development.

Audience: Educators; youth leaders and general public, including adolescent boys.

Produced by: Electra Studio.

Distributed by: Scott Paper Co. Home Service Center, Philadelphia 1, Pa.

BOOK NOTES

HEALTH AND THE SCHOOL CHILD. Compiled and edited by Elmer W. Weber. Charles C Thomas, Springfield, Ill. 1964. 385 pp. \$10.50.

The 21 articles in this collection discuss policies and practices in the administration of school health programs, and describe the child's needs for healthy growth and development and so some specific aspects of health care—nutrition, immunization, control communicable disease, sight conservation, dental health, and mental health.

Emphasis is placed on the importance of periodic physical examinations, and ample forms are included for use in health appraisal.

Consideration is also given to the problems of dealing with exceptional children in school—the crippled, deaf, hard-of-hearing, blind, partially sighted, and mentally retarded, as well as those children with speech defects.

The authors include physicians of various specialties, school health nurses, health educators, and a dentist. According to the editor, the book is directed to teachers, school administrators, school and public health nurses, parents, and community health authorities.

THE PSYCHOANALYTIC STUDY OF THE CHILD. Volume XIX. Ruth S. Eissler, Anna Freud, Heinz Hartmann, Marianne Kris, editors. International Universities Press, New York. 1964. 439 pp. \$10.

The 23 articles in this 19th annual volume of psychoanalytic papers are presented under three main subject headings:

1. "Contributions to Psychoanalytic Theory" contains four papers on concepts in psychoanalysis, including one concerned with the significance of individual differences for later development.

2. "Aspects of Normal and Pathological Development" contains nine papers on the determinants of development, two which are concerned with blind chil-

dren, two with adolescents, and one with the genetic factors in the genesis of "helplessness and hopelessness."

3. "Clinical Contributions" contains nine papers, five of which deal with the reactions of children to death.

NEUROLOGICAL MECHANISMS OF HEARING AND SPEECH IN CHILDREN. Ian G. Taylor, M.D., D.P.H., with a foreword by Sir Alexander Ewing. Manchester University Press, Manchester, England. U.S.A.: The Volta Bureau, Washington, D.C. 1964. 237 pp. \$6.70.

In this book, the author, an audiologist, summarizes current knowledge of the pathological conditions that result in communication problems in children, with special emphasis on the clinical techniques used to diagnose difficult cases. He also presents case stories from his own longitudinal clinical research on children with communication problems stemming from, or complicated by, disorders affecting the peripheral mechanism of hearing; cerebral damage without evidence of cerebral palsy; mental defects; cerebral palsy; and visual defects.

The book devotes considerable attention to the use of the encephalogram during sleep as a diagnostic tool. It also emphasizes the importance of purposeful parental stimulation in bringing speech to the child with a hearing handicap.

THE PARENT AND THE FATALLY ILL CHILD: a demonstration of parent participation in a hospital pediatrics department. Maurice B. Hamovitch. City of Hope Medical Center, Duarte, Calif. 1964. 152 pp. Single copies of the book are available without charge from the Medical Center.

How effective is a parent participation program in helping the families of fatally ill children deal with the crisis in as healthy a manner as possible? Can it help the children achieve the best possible adjustment to their illness and hospitalization? What does the

hospital staff think of it? The answers to these and related questions are found in this 5 year study of such a program at the City of Hope Medical Center, a voluntary hospital in Los Angeles County. The author is professor at the School of Social Work, University of Southern California. The project was supported by a grant from the National Institute of Mental Health.

The program was set up in 1952 to try to lessen for patients and parents the emotional trauma accompanying hospitalization. The planners believed that the more closely the families' ties and roles were retained, the less psychologically devastating for patient and parents. In this program, parents can visit between 7 a.m. and 8 p.m. and participate in the "bathing, feeding, clothing, taking temperatures, etc." During the period of study, doctors met biweekly with the parents as a group to discuss current research in the diseases their children suffered. There were also opportunities for parents individually to discuss with the medical staff the condition of their own child.

The sample studied included 82 cases of leukemia and sarcoma which ended in death between October 1960 and September 1963. The fatally ill children ranged in age from infancy through 15 years. Among the study's findings:

- In more than two-thirds of the cases the parent participation program was judged to be an effective means of helping families and their fatally ill children to deal with the catastrophe "in an adequately constructive manner." In one-fifth of the cases, the program was not successful in reversing marked problems in adjustment. In one-eighth of the cases, the program was "actually a negative factor in the overall adjustment." Dr. Hamovitch concludes that the program is "generally successful" but is not a panacea.

- A stable marital relationship between the child's parents seemed to be of greatest significance in the ability of families to cope with their problems and to benefit from participating in the program.

- Children beyond the age of 10 and their parents displayed more problems than younger children and their parents.

- The first 3 months in the hospital was the most difficult for nearly all parents.

IN THE JOURNALS

Coordinated Treatment

As soon as a delinquent girl is committed to a training school, services to her family should be coordinated with treatment, according to Phyllis R. Snyder, discussing, in the January 1965 issue of *Social Casework*, this coordinated approach as practiced at the New York State Training School for Girls, where she was formerly director of community services. ("Coordinating Residential and Community Treatment of Delinquent Girls.") At the school the resident social workers and field workers begin their work simultaneously on each new girl's arrival.

The school has found that "mother-daughter relationships are more likely to be worked through and resolved" if the mother has developed a good relationship with the field worker before the girl's return home. Conversely, the girl, after she has met her field worker, who represents a tie to the community, "feels more cared for and surer that plans are being made for her."

Decisions as to when a girl should return to the community—including, of course, the decision as to whether she should return to her family or be placed outside her home—are made by the school's Progress Review Committee. They are strongly influenced by the reports of the girl's social worker and her field worker, reports which are prepared only after several evaluative meetings between these two social workers.

American Education

The first issue of a new periodical, *American Education*, published by the U.S. Office of Education, appeared in January 1965, supplanting the agency's two former periodicals, *School Life* and *Higher Education*.

The first of its eight major articles reviews the progress in school desegregation in the 10 years since the historical Supreme Court decision. ("Ten Years of Deliberate Speed," by Erwin Knoll.) Finding compliance "token at best," the author, Washington correspondent for the Southern Education

Reporting Service, maintains that at the rate this has occurred in the past 10 years, it "would take centuries for the public schools of the Deep South to achieve full desegregation." But he finds hope for increased speed in school desegregation in both the North and South from the "judicial, legislative, political, and social pressures now at work."

Other articles described the "cultural deprivation" of deaf children and the importance of providing them with communicative stimulation from their earliest years ("Talk, Talk, Talk to Deaf Children," by Mrs. Spencer Tracy); the variety of vocational education programs being offered by school systems in various parts of the country ("An All-Age, All-Job Program," by Walter M. Arnold); and current experiments of public school systems in providing stimulative education to preschool children from deprived homes ("Headstart for Children in Slums," by Helen K. Mackintosh and Gertrude M. Lewis).

Is Group Care Bad?

On the basis of an examination of the present-day emphasis in the Soviet Union and Israel on child rearing in group settings as "the preferred foster care method of child-raising," Martin Wolins, in the January 1965 issue of *Child Welfare*, raises the question of whether the United States should not "find out whether group care cannot be more useful here." ("Another View of Group Care.")

The author points out that in the Soviet boarding school (*shkola-internat*) and group-care facilities of Youth Aliyah and the *kibbutzim* in Israel, the primary concern is for the collectivity, the social matrix, and not just the individual alone, whereas the American emphasis has always been on the development of independent individuals.

More study of these and other group-care settings will be needed, he says, but he holds that the very existence of these programs should stimulate us to question "the elaborate mythology"

built around institutional care in the country. Group care, he suggests, may not necessarily be bad for child rearing in a society which is no longer competitive oriented as it once was.

Specifically, he suggests that group care be used in the United States for "acculturation" of the children of certain categories of AFDC recipients."

Mary Ellen Hoffman, discussing the article in the same issue, expresses doubt of the value of group care for the . . . children and purpose outlined but concludes: "I think we shall find it desirable to make more and more use of group methods . . . without necessarily removing children from the parents' care."

Adolescent Suicide Attempts

The ratio of attempted suicides to actual suicides among adolescents is in the magnitude of 100 to 1, according to Dr. Harold Jacobziner of the New York City Department of Health, writing in the January 4, 1965, issue of the *Journal of the American Medical Association*. ("Attempted Suicides in Adolescence.")

On the basis of a study of 587 confirmed attempts at suicide by chemical means in individuals between 12 and 20 years old, reported to the New York City Poison Control Center during 1961, the author found that the highest incidence was at ages 19 and 18.

In about half the cases, the family was of medium socioeconomic level; 38 percent, of low socioeconomic level. (". . . many occurrences in the high level group may go unreported . . . the author suggested.)

In 21 percent of the cases, the adolescent's parents were not living together.

Among the reasons for the attempts as stated by the victim or the family were quarrels with family, relatives, friends, or a lover; depression; school difficulties; poor health; illegitimacy; pregnancy; difficulty with the law; an unspecified "nervous" and "emotion upset."

Noting that many suicide attempts by adolescents do not reflect a desire to die, but rather are warnings or pleas for improved relationships, the author concludes that psychiatric aftercare for at least 3 months after an attempt is "far more important than the immediate medical emergency care which is provided."

READERS' EXCHANGE

WITMER: *The right to dependency*

Helen Witmer's article, "Children and poverty," in the November December 1964 issue of CHILDREN performs a kindly needed rescue service for children lost in the fog of our preoccupation with a vague generality called "the poor."

During the past year, we have given our national complacency a healthy jolt through manifold reminders that general affluence has produced no real guarantee against poverty for considerable proportions of our population. But to some degree the popular mania for over-magnification has reduced poverty itself to an abstraction in which "the poor" become one amorphous mass, undifferentiated either as to the cause or remedy for their condition. In my opinion this disposition toward over-magnification acts as a barrier to the institutional changes which alone can prevent poverty.

People have a natural disposition to focus their attention on that particular kind or attribute of poverty which they find the least threatening and then project this upon the whole phenomenon. It is, for example, a lot easier to talk about "pockets of poverty" in the hills of West Virginia, or poverty as a *product* of slums, than to face the fact that the high incidence of rural poverty is literally *forcing* people into urban slums because we make no better working and living provisions for them.

Similarly there is a general disposition to concentrate on the personal attributes of poverty—inadequate education, poor motivation, and general alienation—rather than on its basic social causation. All this is fine if it leads to awareness of the urgent need for a high level of universally available education for all, with specialized aid for those with special needs, enough jobs to move into, and above all a democratic society unshackled from racial and other restraints to social mobility.

But perhaps the most seriously distorting overgeneralization is the tendency to think of the answer to poverty solely in terms of *work*. Miss Witmer's

article makes it abundantly clear that the 17 million children who are poor are not yet ready to work and never will be if they are prematurely forced into the increasingly competitive labor market. Moreover, those children who are solely dependent on a mother may have a very poor chance of achieving their full potential if their mothers are forced into the labor market or are increasingly impoverished by the weight of public disapproval and tightening assistance standards.

There is a tendency today to talk as if "dependency" were always an unmitigated evil. But children are *entitled* to be dependent during the years they are preparing to become fully responsible adults. If their parents cannot, unaided, provide them with these necessary years of dependency, society has an obligation to help. The question is not *whether* but *how*: how to assure to every child the necessary wherewithal for his growth in terms of dignity, security, and participation in the society of which he is so central a part.

Elizabeth Wickenden

Technical Consultant on Public Social Policy, National Social Welfare Assembly, New York

FANSHEL: *More on Shared Fate*

As the organization representing adoptive parents groups throughout the United States and Canada, we were especially interested in David Fanshel's essay-review of David Kirk's "Shared Fate," which offers a theory of the nature of the adoptive relationship in our culture. [An *Upsurge of Interest in Adoption*, by David Fanshel, September-October 1964.]

To us, Dr. Kirk's book represents the first important contribution on the nature and meaning of adoption. It speaks directly and meaningfully to us as adoptive parents. We were, therefore, distressed to find Dr. Fanshel describing the book's theory as something that had been "spun out" and would be of interest to "enthusiastic supporters of theory-building." He accuses Dr. Kirk of a "churlish concern about

efforts to establish professional standards for child placement" and of "unwarranted swipes" at the social work profession. He maintains that Dr. Kirk has used faulty data and has not examined the most current publications in the child adoption field. All this seems to us to represent a rather churlish unwillingness to recognize the importance of what Dr. Kirk has done in going to adoptive parents themselves and their actual experiences and attitudes for the raw material upon which he then, with compelling logic, builds his theory.

It has long distressed us as adoptive parents that the social work profession has itself had the tendency to "spin out" theories without making any attempt to test them empirically. For example, in this very review Dr. Fanshel criticizes Dr. Kirk's belief in the value of adoptive parents groups by saying that they may create "cultist organizations which can help divorce their members from the mainstream of normal living." Yet Dr. Fanshel has never made any study of the actual working of adoptive parents groups—he "spins out" his own web of fantasy devoid of any data whatsoever.

Dr. Fanshel maintains that Dr. Kirk's thought is out of contact with much of the thinking of today's adoption agencies. If this is so, it might well be the obligation of today's adoption agencies to bring their thinking more in line with that of Dr. Kirk. From the point of view of adoptive parents, there is severe danger that adoption agencies and their spokesmen are becoming themselves more and more cultist organizations divorced from the reality of what it is to be a member of an adoptive family.

Arthur Glickman

President, National Council of Adoptive Parents Organizations, Teaneck, N.J.

Author's reply

Like Dr. Kirk, Mr. Glickman is a strong advocate of the promulgation of adoptive parents' clubs and views with considerable misgiving anyone who does not completely accept as valid the theoretical rationale for the formation of such organizations. This is quite understandable.

However, I object to the obvious manner in which he quotes me out of context. For example, he quotes only the italicized words in the following sentence from my review: "The theory

spun out by the author will prove fascinating not only for readers interested in adoption but also for those who are *enthusiastic supporters of theory-building* in the behavioral sciences and social sciences." The implications Mr. Glickman sees in the sentence are of his own contrivance.

In his letter-to-the-editor, Dr. Kirk claims that what I had referred to as a "method" was simply "an unintended dramatic event." ["Readers' Exchange," November-December 1964, p. 244.] I would still maintain that his use of his own adoptive parent status in soliciting responses from adoptive par-

ents about experiences they have encountered in the community was a questionable procedure which might have resulted in his securing invalid responses to research questions.

Dr. Kirk has expressed objection to my stating that the data he presents to support his theory are sketchy and to my assertion that they provide only a rather tenuous underpinning to his formulations. He cites the fact that in analyzing his mailed questionnaire he achieved a Guttman Scale of high reproducibility and states: "This finding provides strong evidence that the responses are representative of genuine

social experience, and so supports the validity of the data." The main contribution of the scaling technique he has employed is to determine whether the items used belong to the same attitudinal domain. Therefore, one might consider his finding a test of internal validity for the items he has used. Thus far however, he has failed to meet the problem of external validity by providing data which support the view that kind of biological chauvinism exists in the community at large.

David Fanshel

Associate Professor, Columbia University School of Social Work

Guides and Reports

PROCEEDINGS: ONE-DAY INSTITUTE ON INTEGRATION OF THE MENTALLY RETARDED IN A COMMUNITY GROUP SERVICE AGENCY—A LOOK AT KNOWLEDGE, METHODS AND GAPS. 1964. 52 pp. \$1.

PROCEEDINGS: ALL-DAY INSTITUTE ON INTRODUCTION OF A NEW SERVICE: DEVELOPING GROUP WORK AND RECREATION RESOURCES FOR THE MENTALLY RETARDED IN THE COMMUNITY GROUP SERVICE AGENCY. 1964. 45 pp. 50 cents. The Association for the Help of Retarded Children, New York City Chapter, 200 Park Avenue South, New York, 10003.

Reports of two institutes, the first held at the Kennedy Child Study Center in December 1963; the second, at the Association's office in February 1964.

A VIEW FROM THE BENCH; the juvenile court. Hon. Justine Wise Polier. National Council on Crime and Delinquency, 44 East 23d Street, New York, 10010. 1964. 86 pp. Single copies free from the Council.

Reports on a study made in New

York City in 1962 to examine the operation of judicial administration in the Juvenile Term of the Family Court, appraise the quality and quantity of services needed for children who appear in court, and determine the structure for effective administration of a family court and its goals.

INSTITUTION OR FOSTER FAMILY: a century of debate. Martin Wolins and Irving Piliavin. Child Welfare League of America, 44 East 23d Street, New York, 10010. September 1964. 62 pp. \$1.50.

An examination of the issues involved in differing views over the relative merits of foster family or institutional care for children—today and in the past—in the light of what is known or not known on the basis of empirical research.

ROUND-THE-CLOCK COVERAGE IN CHILD PROTECTIVE SERVICES. Children's Division, The American Humane Association, Post Office Box 1260, Denver, Colo., 80201. 1964. 20 pp. 35 cents.

Contains three papers which describe the after-hours services of three child protective agencies—the Children's Aid and SPCC of Erie County, Buffalo, N.Y.;

the Children's Aid Society of Metropolitan Toronto; and the Oahu Division of the Hawaii State Department of Social Services.

PROCEEDINGS OF WORKSHOP ON INFLUENCING THE POSITIVE USE OF CRISIS. Tulane Studies in Social Welfare, Vol. 5, 1962. School of Social Work, Tulane University, New Orleans, La. 1964. 99 pp. Single copies available to agencies and professional schools on request.

Reports on the second of two workshops on medical social work with handicapped children and their parents. The first was "The Significance of Health and Handicap in the Growth and Development of the Child."

REPORT OF THE DEPARTMENT OF HOSPITALS' COMMITTEE ON PSYCHIATRIC SERVICES FOR CHILDREN TO THE COMMISSIONER OF HOSPITALS, NEW YORK CITY. New York City Community Mental Health Board, 9 Worth Street, New York, 10013. June 1964. 55 pp. Copies available from the Board on request.

Reviews the "major, basic operational problems around mental health services for children in a big city," especially in relation to the use and misuse of municipal hospitals, and makes 30 specific recommendations for improving service to children.

SOME U.S. GOVERNMENT PUBLICATIONS FOR PROFESSIONAL WORKERS

Publications for which prices are quoted are for sale by the Superintendent of Documents, U.S. Government Printing Office, Washington, D.C., 20402. Orders should be accompanied by payment. Twenty-five percent discount on quantities of 100 or more.

REPORT ON DAY CARE: meeting of representatives of State Advisory Committees on day care services and State Departments of Public Welfare, March 19-20, 1961. Department of Health, Education, and Welfare, Welfare Administration, Children's Bureau, Child Welfare Report No. 11, 1961, 51 pp. Single copies available from the Bureau without charge.

The proceedings of a meeting called by the Children's Bureau to discuss the States' problems and progress in the provision of day-care services. The texts of addresses by the Commissioner of Welfare, the Assistant Secretary of Labor, and the president of the National Committee for the Day Care of Children are included, as well as summaries of reports from the States and the ensuing discussions.

DAY CARE FOR YOUR CHILD IN A FAMILY HOME. Department of Health, Education, and Welfare, Welfare Administration, Children's Bureau, CB Publication No. 411, 1964, 14 pp., 15 cents.

This pamphlet is addressed to working mothers who must select a family

day-care home on their own because their community does not provide help in this direction. It offers guidelines to assist the mother in choosing a proper physical and social environment and a responsible day care mother; and hints on how mother and day-care mother can work together in the best interests of the child.

**CONVERGING SOCIAL TRENDS
EMERGING SOCIAL PROBLEMS.** Department of Health, Education, and Welfare, Welfare Administration, Division of Research, WA Publication No. 6, 1964, 96 pp., 55 cents.

The 54 annotated charts and 38 tables in this pamphlet illustrate some of the social forces which are creating imbalances in the Nation's social structure and the human problems that result. Among other relation shifts they illustrate: the contrasting effects of automation on job opportunities for the highly skilled and the unskilled; the adverse effects on earning power of color, female sex, and low education; the effects of race, sex, and geographic area on educational attainment; the effects of medical advances on costs of

health care. Also included are data showing increases in families with no father in the home and of the proportion of married women who are employed.

THE COMPREHENSIVE COMMUNITY MENTAL HEALTH CENTER: CONCEPT AND CHALLENGE. Department of Health, Education, and Welfare, Public Health Service, National Institute of Mental Health, PHS Publication No. 1137, 1964, 22 pp., 15 cents.

This booklet explains the opportunity provided communities through the Community Mental Health Centers Construction Act of 1963 for receiving Federal help to establish comprehensive community centers for treating mentally ill persons in their own communities; discusses the advantages of such centers to patients; and gives examples of centers already in operation.

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AN INTERDISCIPLINARY JOURNAL FOR THE PROFESSIONS SERVING CHILDREN

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MAY • JUNE 1965

AN INTERDISCIPLINARY JOURNAL FOR THE PROFESSIONS SERVING CHILDREN

Use of Child Welfare Manpower Welfare and Medical Services The Hospital—the Child's View Children Learning From Children





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LEARNING TO READ is an obviously exciting adventure for these two children in a preschool center for cerebral palsied children. How one such center recognizes in its admission policies the importance to even

the most severely handicapped children of having opportunities to learn whatever physical, social, and communicative skills they can master is described in the article beginning on page 105.

A psychologist whose major interests are public administration and child welfare research, Donald Brieland has headed the Illinois child welfare program since 1961. Previously director of the Elizabeth McCormick Fund, which specializes in child health studies, he has taught at Northwestern University and at the University of Minnesota.



A graduate of the McGill University School of Social Work, Montreal, Margaret A. Dennis has practiced as a medical social worker in the United States, Canada, and England. She took her present position at New York Hospital in 1961. A previous paper by Miss Dennis on other aspects of the project described has appeared in *Social Casework*.

Martha Adams (left) and Dorothy Berman became interested in children's reactions to hospitalization while supervising Boston University School of Nursing students caring for children in a hospital. Miss Adams is now assistant professor in maternal and child nursing, University of California School of Nursing. Mrs. Berman once worked with deaf and mentally retarded children.



In addition to working with cerebral palsied children at the preschool center she describes, Malinda Gay is doing graduate work in exceptional education at the State University of New York, College of Education, at Buffalo. With a B.S. in education, she is certified both as a teacher in art and as a teacher of physically handicapped children.



Since writing his article, I. N. Berlin has left California—where for 15 years he gave school psychiatric consultation—to go to the State of Washington, to become professor of psychiatry and director of the division of child psychiatry, University of Washington School of Medicine. His interest in learning problems stems from his work with schizophrenic children at the Langley Porter Neuropsychiatric Institute, California State Department of Mental Hygiene.



Peggy Lippitt, who received her master of education degree at the University of California, Los Angeles, has taught at the University of Michigan Laboratory School. She is now coordinator of the cross-age demonstration project described in the article. John Lohman, a social psychology doctoral candidate at the university, conducts research in several types of peer cultures.



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THE EFFICIENT USE OF CHILD WELFARE PERSONNEL

DONALD BRIELAND

Director, Illinois Department of Children and Family Services

THE MANPOWER PROBLEM is a dominant concern today in all the fields of service to people. Public child welfare programs are among those faced with an urgent necessity to find creative solutions. The goal set for these programs by the 1962 amendments to the Social Security Act is to achieve full geographic coverage with professionally trained staff by 1975. This entangles them in a paradox. The rapid rate of program expansion is resulting in a continuing decrease in the proportion of professional staff to total staff, even though the number of professionals increases. Thus the programs must move in what seems to be two directions at once—the protection or improvement of the quality of service and the rapid extension of coverage to all children needing service.

The provisions of the Economic Opportunity Act of 1964 add to the urgency of the problem. Its anti-poverty programs will make the shortage of professional personnel more acute by creating more job opportunities for professional social workers. At the same time, these programs will include many community projects in which social service functions will be performed without the use of professional social workers, either in direct service or supervisory positions. A number of these programs will focus on the "culturally deprived" child and will be of concern to State and local officials responsible for child welfare.

The key to the manpower problem in social serv-

ices may lie in the way personnel is used as well as in a broader conception of staff development. The Children's Bureau sponsored a meeting on the use of case aides in 1959. More recently, the National Association of Social Workers has developed a theoretical model for the use of personnel.¹ The NASW has also undertaken some pertinent activities with the U.S. Department of Health, Education, and Welfare: development of demonstration project designs in differential use of staff with the Bureau of Family Services; and the sponsorship of a research conference on manpower with the Children's Bureau. The Bureau of Family Services has been working on proposals for multiple career lines in public family services as an outgrowth of an educational standards project begun in 1959. And DHEW has issued a publication summarizing the need for research in social work manpower.²

A Wisconsin committee drawn from the field of public welfare and the schools of social work recently identified six points of difficulty which underscore the need for new approaches to the use of available personnel.

In brief the points are:

1. The production of professionally prepared social workers is not meeting and never will meet growing staff needs.
2. The personnel gap has been and will continue

to be bridged by the appointment of staff who do not have the master's degree.

3. Tasks assigned to nonprofessional and professional staff tend to be identical.

4. Professional staff have been expected to perform tasks for which they are "over educated."

5. Some elements in concepts of the supervisor-worker and client-worker relationships block experiments in the differential use of personnel.

6. Inf flexibility in staff usage also stems from the idea that all tasks of case service should be performed by a person with maximum skill, so that every diagnostic and treatment potential can be exploited.

In an unpublished statement, the committee emphasized the interlocking responsibilities of the social work profession, schools of social work, and social welfare agencies for seeking solutions to the problem. It maintained:

Solutions to the manpower problem can only occur if serious study is undertaken of the demands of the job of casework service, while holding in abeyance any traditional concepts of the job which have mitigated against experimentation. Further solution to the personnel and training aspects of the manpower problem can be advanced only as innovative efforts are designed in a framework of cooperation and collaboration. Any proposed solution must, therefore, touch base with the problems of task differentiation, personnel policies and practices, administrative organization, education and training, and conversion from the current pattern to more effective patterns.

Differential Staff Use

What is involved in the differential use of manpower?

While the general goal is to provide more service more effectively, there are important subgoals:

1. To maximize the contribution of professionally trained workers.

2. To facilitate efficient and rapid development of skills for younger professional workers.

3. To utilize the energies of workers who have only bachelor's degrees, so that they are engaged in the tasks most adequately suited to their skills.

4. To differentiate roles and tasks to make possible the most efficient orientation and staff development programs.

5. To put as much effort as possible into direct services to children and families without neglecting the obligation for reporting.

6. To provide staff at all levels with career lines, a sense of status and responsibility, and an agency climate that will result in good morale and a high rate of staff retention.

The fear is always expressed that experimentation to reach these goals will dilute professional function and impair service. However, many of the functions now carried on by professional staff members are subprofessional in nature. Differential use of manpower should free the professional to use his special skill more widely.

In the child welfare field, the manpower problem is often considered at only two levels, the professional caseworker and the worker with only a bachelor's degree. However, at least eight different personnel categories can be considered for purposes of manpower research.

These eight categories are:

1. Caseworkers with a master's degree in social work as their minimum qualification.

2. Persons with a master's degree (or higher) in related fields.

3. College graduates with casework experience.

4. College graduates with no experience but with an interest in child welfare and perhaps in graduate social work education.

5. Foster parents and others from whom the agency may purchase service.

6. Clerical employees, generally with a high school education or above.

7. Volunteers representing wide variation in interests, education, and skills.

8. Former public assistance or child welfare clients.

In projects aimed at the more efficient use of manpower in child welfare programs, it is appropriate to involve not only supervisory and casework staff, with and without professional training, but clerical personnel as well. Some of the tasks being performed by caseworkers can probably be assigned to clerical personnel.

It is also important to consider volunteers—what roles they now play, what they can do, and how they can be recruited. The creative use of volunteer promised in the community action programs under the Economic Opportunity Act may provide useful examples for child welfare agencies, which rarely use this source of supplementary manpower.

Three specific suggestions to assist in differential use of manpower need serious exploration: (1) the development of teaching materials for nonprofessionally trained staff who have bachelor's degrees; (2) special training programs for workers too isolated to participate fully in a team; and (3) a team approach to public child welfare functions.

Teaching Materials. Indirect teaching methods, such as theoretical discussions, are not sufficient for training subprofessional child welfare staff. Workers need to observe and participate directly in activities that illustrate skill in practice. Especially helpful in this connection are films and tape recordings of agency activities and interviews involving various aspects of the child welfare programs, such as child placement, services to children in their own homes, court hearings, services to unmarried mothers, and day care. Through such materials, new approaches being tried in both tax-supported and voluntary agencies, as well as the traditional methods of providing services, can be illustrated.

The use of such materials should be supplemented by opportunities for subprofessionals to participate with qualified senior workers in actual interviews with clients. Fortunately, many of the objections to using audiovisual devices and joint interviewing—based on an exaggerated conception of confidentiality—have been overcome.

So far, public child welfare agencies have made little use of modern devices to develop examples of primary process. A few experiments have been carried on, mainly in schools of social work. There, the need is much less than in public agencies, where many workers have not had the exposure to graduate school and field training.

One of the most promising suggestions for the field of public welfare is the establishment of a teaching materials center which would produce films, tapes, and teaching guides, and collect case records and other teaching materials to be made available to public welfare agencies at cost. The recent award of a \$30,000 grant from the Field Foundation to the Council on Social Work Education indicates that such a center will soon get under way.

Educating the Isolated Worker. Many counties do not have any professionally trained public child welfare workers, and, realistically speaking, will not have any in the foreseeable future. In some of these counties, staff members are isolated by distances or by county jurisdictions and thus are kept from receiving adequate professional supervision or from participat-

ing in a team made up of both professional and non-professional workers.

These isolated workers often have valuable assets, especially since they are usually well-informed about their communities. Regardless of their lack of professional training, they are considered to be child welfare experts by judges, public health nurses, school personnel, and other local leaders; and indeed their experience and judgment may make them experts.

Such personnel need frequent opportunities for on-the-job education. Mobile training units can be developed. Also, groups of workers from smaller counties can be brought together for formal training courses and for sharing experiences and receiving consultation on actual cases. In addition to profiting from consultation from professionals, workers can help each other learn. A teaching materials center could provide valuable help for both group activities and individual self-instruction.

The Team Approach. The team approach provides for the close working together of professionally trained and subprofessional workers, with the responsibilities of each clearly defined by the agency. A prerequisite of this approach is a careful analysis of the tasks involved in the agency's services, followed by a continuing staff development program for all agency personnel.

Some Experiments

A few experiments are already under way, aimed at more efficient use of available child welfare staff.

One approach is to differentiate fact-finding tasks from other child welfare functions and to train persons with a bachelor's degree to carry them out. For example, the Jane Addams Graduate School of Social Work, University of Illinois, with the use of Federal funds from the Children's Bureau, has analyzed the tasks involved in licensing independent foster homes and foster day-care homes and has trained nonprofessionals for them.³

Much effort has gone into the creation of public child welfare agencies of short-term trainee positions for college graduates, giving them a chance to practice casework and then go on to graduate school on stipends provided by the agency through the use of Federal child welfare services funds. This has the advantage of giving both the student and agency a trial period. An analysis needs to be made of the performance of trainees who have majored in social welfare in an undergraduate college, compared with

the performance of those with other educational backgrounds.

Much effort has also been expended in staff development programs for trainees and for regular child welfare staff members who hold only a B.A. degree. Generally, the two programs differ in content because the trainees are in transition between college and graduate school and the regular workers are being trained primarily for immediate responsibilities in the agency.

Most State child welfare directors can point to informal, pragmatic efforts in local units to develop criteria for the assignment of cases based on levels of training. The general guidelines vary, depending on the insight and teachability of the individuals. Few of the projects have been described in print. Pertinent, however, for the child welfare field in general is a project in the voluntary sector—an experiment in the use of nonprofessional college graduates being carried out by the Spence-Chapin Adoption Service in New York.⁴

Most of the informal efforts being made in public agencies toward differential use of child welfare manpower are based on the traditional model of a primary casework relationship between one worker and the family. The differentiation comes in the assignment of the case according to the degree of complexity of the client's needs. The "easier" cases go to the subprofessional worker; or, the apparently long-term cases and the apparently short-term cases are differentially assigned.

Both smaller caseloads and differentiation of cases by level of difficulty were used in the project by Weed and Denham,⁵ in which 50 preprofessional workers from 18 child placement agencies in New York City were given special training to carry placement cases.

Since both difficulty and length of service are imprecise criteria at the time of intake, and there are apt to be many changes in the staff and in the client's situation in the course of service, the tendency may be for everyone to end up doing the same thing.

A Demonstration Project

A 5-year demonstration project just getting under way at the Illinois Department of Children and Family Services is taking a different approach. The goal is to extend the use of professional skill with teams made up of a professional worker and several subprofessional workers, with a differentiation of responsibilities for the same cases according to the abilities of each. The major objective is to demonstrate the feasibility of the team approach. Because

this is a departure from typical procedures in public child welfare programs, the rationale and goals will be described here in further detail.

Our greatest concerns in planning the Illinois project have been goal-setting and devising built-in methods of evaluation. Scientific research on a problem with so many uncontrollable variables is difficult to design. Yet without careful evaluation a demonstration project may result in an automatic "A" for effort without any real assurance that the method demonstrated represents any gain over previous approaches. We expect such a team approach to extend the use of professional skill and knowledge so that staff can be deployed to provide quality service and more adequate coverage. At the same time, we hope that the project will help increase staff morale and interest.

Goals and Assumptions

We expect to concentrate on two processes—*intake* and *foster family care*. A concentration on intake is important for securing adequate data on the initial aspects of the cases and the decision-making that goes into the diagnosis of the problem.

Intake is also of interest because of the considerable disagreement today concerning the training needed by intake staff. The problem is complicated by differences in definition. If intake is seen as screening before case assignment, the knowledge required may be different from that needed for carrying out a longer process of diagnosis and development of a tentative plan to meet the child's needs.

One of the basic questions we hope to answer is the degree to which the conclusions reached at intake are validated later. If diagnosis at intake is usually modified substantially as the child is served, less effort at intake might be directed toward a detailed formulation and an assignment made earlier to the regular casework staff.

A lengthy intake-diagnosis process, preceding acceptance of the family for service, may have serious negative effects on client motivation. Since the Department's various units operate with several different philosophies and patterns for intake, the project will provide some basis for comparison.

To keep the project of manageable size, detailed analysis will be limited to foster family care. Comparisons between project cases and regular cases will be made in terms of length of placement and the proportion of replacements in each group, as well as in the development of special behavior problems. Attitudes toward agency service by both foster and

natural parents will be determined by independent interviewers.

The project is based on the theory that foster care can be profitably studied as a decision-making process involving various functions and levels of complexity. A listing of the decision-making abilities of professional workers and subprofessionals with a bachelor's degree indicates few differences in the characteristics of the two groups of workers. Persons in either category may be observant, logical, and adept in applying a sound method to the problems under consideration, within their respective areas of responsibility. The difference between the two groups is that the education and background of the worker who is professionally trained allow him to understand more fully the real nature of the problems involved. From this, it should be possible to differentiate functions so that each category of workers performs effectively within clearly defined ranges of decision-making responsibility.

In the project, it is assumed that operations consisting of tasks that can be set forth fully in a manual involve little need for professional skill. From guidelines provided, the subprofessional member of the team can make the necessary decisions.

Some questions demanding decisions are in a middle range of complexity, and all their elements cannot be anticipated by manual material. In such instances, the subprofessional can call on the professional worker for validation of his decision, as is now done in the process of supervision.

Finally, some decisions in the foster care process require direct involvement of the professional worker because of their gravity, complexity, or uniqueness.

Foster Care Teams

While the size and organization of child welfare teams might vary widely, the foster care teams in Illinois are to be made up of a professional worker and several nonprofessionally trained college graduates. All will have had full orientation and inservice training concerning foster family care. The professional worker will have a master's degree in social work and a minimum of 6 months' experience in the agency. Case assignments will come to him. Typically, he will have firsthand contact with the client families for initial planning and for special problems or crises. The family will expect service both from him and from the junior worker, but will not ordinarily receive information on the rationale for the workers' differential responsibilities.

Conferences between worker and supervisor will

largely be replaced by the relationship between the junior worker and the professional worker. The supervisor will be responsible for case assignments to the team in order to keep the work load of the agency balanced. He will serve on request as consultant on the case, but he is required to be involved in only one decision—termination of service. The supervisor is also expected to carry staff training responsibilities.

Modifications in recording are contemplated, but recording requires no more time than workers now spend and possibly less. Each team will have a clerk assigned to it. Plans are to determine which of the functions carried on by the child welfare workers can be reassigned to a clerical worker.

Through the foster care team, we hope to give to the professional worker higher levels of responsibility; to the subprofessional, specific inservice training and experience; and to both, the stimulation of team participation. At the same time, we expect to have a method for extending professional skill to deal effectively with crises and other major problems.

We believe that the flexibility provided by this team approach in child welfare effectively takes into account the two yardsticks recommended by the NASW commission on practice for determining the division of responsibility among social agency personnel—the degree of the client's vulnerability to stress and the degree of the worker's ability to function autonomously.

This team approach to staff use is conservative in that it recognizes the importance of the relationships between client and agency staff. The fact that it enlarges the scope of the relationship with a family to involve more than one worker may result in clients identifying more with the agency than with an individual worker. However, even in traditional ways of operating, when longer term service is provided, the passing parade of workers may make the agency rather than any one individual the stable element in the relationship.

Other Experiments Needed

Many more innovations and systematic research-demonstrations are needed to test out both present assumptions and new methods of staff use, in order to find better ways to deploy professional manpower, to spread scarce skills, and to develop more effective means of training.

We need more radical projects that may involve drastic redesigning of ways of providing service. At the 1965 meetings of the Council on Social Work Edu-

cation, Samuel Mencher of the University of Pittsburgh proposed a public health model⁶ and Arthur W. Blum of Western Reserve University suggested an extension of the institutional treatment model.⁷

The public health model, Mencher said—

draws upon the changing nature of environmental demand for its identity. Social need and the broad field of social welfare rather than established skills would shape the course of professional function for social work. The profession here is not so much concerned with cutting out a unique place for its own practice as finding answers to the ever-changing complexity of social problems. The foothold on traditional professionalism becomes more shaky as we no longer have a well-circumscribed field of operation. The professional is not so much a primary force in his own right as the agent of individuals, groups, and communities in . . . helping [to] bring the vast technical skills and resources of society in line with the welfare of all. . . .

Blum emphasizes the need for a worker—

who has the major responsibility for the case but whose job includes the coordination and utilization of a team of specialists. . . .

This differentiation of tasks and use of a team approach would also provide us the opportunity to build upon the strengths which the worker brings to the agency and make it possible to compensate for weaknesses. One worker would not be expected to be all things to all people.

A multifunctional approach of this kind offers other advantages as well. We would . . . face the necessity of creating a series of job categories which are essential to the services we offer. Jobs could be created which are "respectable," which do not require graduate training, which are not designed specifically as recruitment devices for schools of social work, and which permit promotion and career aspirations to be fulfilled. Employment could begin within the categories which demand routine services or which are dependent primarily on what the worker brings with him to the job. The worker could progressively advance to jobs whose tasks require additional skills and knowledge. The position of professional social worker

could be differentiated in terms of the functions he would perform in this interdependent staff network which are related to and dependent upon his professional education. . . .

Blum also proposes "crisis teams" on 24-hour call. These teams would have special skills. Workers would not have to drop everything to handle emergencies and the client would receive assistance from an agency designed to help him.

Public child welfare programs have been fortunate in having professional social workers in leadership positions. This has made possible the development of high-quality services. However, it has also made for too conservative an attitude toward experimentation in the use of manpower.

There is room for testing out many new approaches. To meet the demands for service, we need a sense of adventure and a willingness to communicate our plans as well as our results.

¹ NASW Subcommittee on Utilization of Personnel: Commission on practice utilization of personnel in social work—those with full professional education and those without. National Association of Social Workers, New York. February 1962.

² French, David G.: Needed research on social work manpower (report to the Task Force on Social Work Education and Manpower). U.S. Department of Health, Education, and Welfare, Welfare Administration Bureau of Family Services. 1964.

³ Costin, Lela B.; Gruener, Jennette R.: A project for training child welfare personnel. *Child Welfare*, April 1964.

⁴ Montgomery, Helen B.: Differential utilization of social work personnel. *Children*, May-June 1964.

⁵ Weed, Vene; Denham, William H.: Toward more effective use of the nonprofessional worker: a recent experiment. *Social Work*, October 1961.

⁶ Mencher, Samuel: The evolving professional function. Paper delivered at the 1965 Conference of the Council on Social Work Education Denver. January 1965.

⁷ Blum, Arthur: Manpower utilization—wishful thinking unfulfilled. Paper delivered at the 1965 Conference of the Council on Social Work Education, Denver. January 1965.

It is never easy to be poor. Hunger, cold, ugliness, thwarted ambition, are always hard but they are harder when one lives with them in the midst of all the goods and all the opportunities, as youth does today. "You can fight your way up," they are told. Certainly there are people, young and old, who have done this and still do it. But we must finally accept the knowledge we have gained in the last decades that man is neither a product of environment nor of his innate heritage, nor of his free will alone. What he is and becomes grows out of a combination of these three factors.

Gisela Konopka, of the University of Minnesota School of Social Work, to the 1965 annual meeting of the American Orthopsychiatric Association.

IMPROVING COORDINATION OF WELFARE AND MEDICAL SERVICES

MARGARET A. DENNIS

Social Service Coordinator

Welfare-Medical Care Project, The New York Hospital, New York City

SINCE THE 1930's, some kind of medical care has been provided for recipients of public assistance. Only recently, however, has attention been paid to the quality of this medical care—and to the kind of medical care facilities which might best serve these recipients. Experimental research is under way in a number of places to discover what kind of care is feasible and the extent to which it can be continuous or comprehensive.

The New York Hospital Welfare-Medical Care Project is one such experiment. Its purposes are to determine the feasibility of giving public assistance recipients complete medical care under the auspices of a voluntary hospital and to study the cost, utilization of medical services, and quality of this care.

Because of the experimental nature of our project, a random selection of public assistance recipients, irrespective of health status, was made. As a result, the social problems encountered in the project covered a wide range of psychosocial disability not primarily stemming from serious illness and physical disability. When such a demonstration takes place in a hospital in which social work is established, social workers are called upon not only to serve clients but also to look for ways to improve working relationships with the

local welfare organization and new ways to coordinate services. Our project experience has shown that our usual methods of collaboration with the New York City Department of Welfare are often inadequate, particularly when clients' problems are complex and when different disciplines and institutional differences are involved.

The New York Hospital-Cornell Medical Center, where the project is located, is a large voluntary teaching hospital. The welfare district served by the project takes in two welfare centers—about 100 city blocks on the East Side of Manhattan. The project patients are clustered at either end of this racially mixed area. Puerto Ricans, comprising more than half of the total number of people in the project, live mostly in the upper end of the district, known as Spanish Harlem.

Between July 1, 1961, and June 30, 1962, 1,028 cases were selected randomly as they became eligible for public assistance, then assigned to the project for medical supervision. By and large, our project patients have required ambulatory medical care.

The project clinic staff works within the hospital's general medical clinic and the pediatric clinic. Our project group consists of a full-time director and an associate, both physicians: internists; pediatricians; a part-time psychiatrist; a nurse; and a social work coordinator.

Based on a paper presented at the 1964 forum of the National Conference on Social Welfare.

The pattern of medical care provided by the hospital's comprehensive care program has been used. Clinic care is given by appointment, or without appointment when patients "walk in." A bed is available in the hospital when necessary, as is the hospital's home care program.

Added features are the following: Individuals and families are entitled to medical care after clinic hours and have access to a project physician by telephone. House calls are made when necessary or when the emergency room is used. Psychiatric consultation for patients has been available from the outset. Care in nursing homes is supervised by a project physician. As a medical care facility of the Department of Welfare, the project accepts responsibility for medical evaluations of pending applications for the aid to the permanently and totally disabled (APTD) program. Work status is evaluated but always in conjunction with continued medical care.

Casework is provided project patients on referral within the existing structure of the Social Service Department. No social workers have been added except the social service coordinator. The bulk of work has fallen to the social workers attached to the general medical clinic and to the pediatrics division, where our project physicians are located.

Problems Encountered

Since our hospital provides medical care and has a Social Service Department, it responds to the needs of the Department of Welfare in two traditional ways. The first is to provide medical information and recommendations. The second is to provide social work within the hospital through the Social Service Department, which is prepared to work cooperatively with the Department of Welfare.

Of the 586 cases in the project for medical care in the past 2 years, approximately two-thirds were referred to the Social Service Department by project physicians. In order of frequency, the types of problems encountered by our social workers during the first year were in the following areas: family relationships, child behavior and child care, personal adjustment; employment and work rehabilitation; facilitation of medical and psychiatric care; financial problems and housing. Chronically dependent single adults and families with a multiplicity of problems became "our clients" also.

We decided to use the project client group to take a look at what the Department of Welfare asked of the hospital and what happened to the medical information and recommendations sent to it. For 18

months, all letters from the two welfare centers concerned were screened by the social service coordinator a physician, and a psychiatrist. We found that medical opinions in relation to employability and work rehabilitation were requested. Psychiatric examinations were requested to determine individual competence to cope with daily living or with welfare requirements; to determine competence of parents to give adequate care to children; and to determine the nature of childhood behavior disorders and to recommend treatment.

The Need for Coordination

Two of our cases show the difference that coordination can make. In the first, no casework assessment was made at the hospital:

Mr. D is a 53-year-old single man, who speaks practically no English and has no relatives in this country. He has no work skills and has always done odd jobs, mostly as a dish washer. He developed a hernia at work and a compensation claim was submitted. He has since refused to have this hernia repaired because litigation is in process.

Nobody at the hospital could find out very much about this man who kept insisting that he was disabled. Despite his hernia, it was thought that there were no reasonable ground for his not seeking employment. But the Employment and Rehabilitation Division of the Department of Welfare had already tried to find employment for him and failed. Our psychiatrist examined him, and in June 1963 we sent the following report to the welfare center:

"Mr. D is a short, lame man who has no serious organic problem, but ever since a foot injury as a child has considered himself disabled. He has a limited intellectual capacity and is not a candidate for training. However, he keeps under regular medical supervision by appointment and occasionally 'walks in.' His headaches and abdominal pain are treated symptomatically. Should there be evidence from your visits or from people in the community, that he is less and less able to manage, please let us know."

In November 1963, a new public assistance worker was assigned at the welfare center. He visited Mr. D and put a note under his door to ask him to go to the hospital for an employment physical examination. The patient came running to the project desk, having developed several new psychophysiological symptoms on the way!

Mr. D, like many a Department of Welfare client with a chronically unresolved problem, was caught up in an unnecessary merry-go-round between the Department of Welfare and the hospital. This kind of unresolved issue which drags on for months and even years can undermine clients with stronger egos than Mr. D's and can contribute to an irreversible state of financial dependency.

What, then, does the Department of Welfare expect of the hospital? Practically nothing in the way of cooperative social work, yet two-thirds of the cases

about which the welfare centers had inquired were known to the hospital social workers. Despite the usual exchanges between the hospital social workers and the staff at the welfare centers, it was obvious that the staff of the centers still looked upon us as dispensers of medical and psychiatric findings. They did not look upon us as co-workers interested in improving the lot of the clients to whom we had a joint commitment.

The following is an illustration of the way in which an appropriately coordinated effort between the hospital caseworker and the welfare center staff can benefit a client and his family. This was a project case, but there were in it no departures from normal hospital casework practice:

Mr. J, a 46-year-old married father of five children, was discharged from a State hospital in 1958 with a diagnosis of chronic paranoid schizophrenia. He was formerly employed as a construction worker, and had been imprisoned at Sing Sing. He had not been employed since 1952. In his mind, this "nervous breakdown" occurred because the Department of Welfare continued to pressure him to return to work. Along with this mental illness, his family situation has been tense and ungratifying.

When Mr. J asked the physician to permit him to return to work, a referral to the hospital social worker was made for evaluation of employment and family problems. Work was contraindicated, but stabilization of the patient and family was urgent. With the help of the hospital social worker, the welfare center has adapted its service to meet the needs of the whole family. The patient, still subject to unpredictable recurrent emotional crises, seeks counsel from the caseworker and the physician. He has stayed out of the hospital and has shown some signs of improvement. He may eventually be able to work.

In this case, the patient was helped by a coordinated approach from medicine, psychiatry, and social work. The hospital contributed an assessment of the total family, ascertained the sources of stress for the patient, and set reasonable goals which were interpreted to the welfare center. It was then possible to coordinate services to the family as a whole.

Some Handicaps

More often than not, however, individuals—and, particularly, families—who came under project care have had complex problems in diagnosis and treatment which defied our usual methods of providing coordinated care within the hospital, to say nothing of coordination with the Department of Welfare. To some extent, we were working under what might be called an institutional handicap in attempting to provide family care.

Even when comprehensive medical care is practiced in hospitals, it is only at best family oriented.

The hospital is "wonderfully one times one," in that the patient rather than the family is the unit of reference. There may be a unit record, seldom a family record. We work in departments or on specific services with policies that often split care. We have unwritten codes which govern how far the institution will extend itself to fulfill its own purpose or serve the community.

The welfare centers may not always reflect the high degree of commitment of the city's executive branch. They are often ruled by categorical requirements, rather than by the needs of individuals or families. In New York City, a specialized medical-social work office exists in each center; it serves as liaison with hospitals and keeps an administrative eye on all medical care services. This kind of administrative separation of medical care from the work units has seriously reduced the investigator's understanding of health problems, has lessened his initiative in working cooperatively with hospitals, and has seriously reduced the effectiveness of the medical social workers as case consultants.

Within the project over the past few years, in an attempt to weld ourselves into a closely coordinated, responsible team, we have tried variations of established methods used in medicine and social work. In our project clinical conferences, we have learned how important it is to have the full benefit of the findings and observations of each discipline reported and then reassembled in group discussions where opinions can be aired. These discussions have aided us in providing coordinated medical care and social work for selected problem families. They have also brought to light new issues on which we have had to take a stand with our Department of Welfare.

In approximately 60 percent of the cases known to the hospital social workers during these 3 years, there has been cooperative work with the Department of Welfare and other social agencies. Significantly enough, it has been the project which, in all but two instances, has called interagency conferences to try to bring order out of chaos or find some means of preventing further breakdowns.

The following case, which gave rise to one of these interagency conferences, was called to discuss coordination of services to families in which parents were not able to give adequate care to children:

The W family consists of a retarded mother, a near-psychotic father, and three children under school age. The mother's distracted inability to manage simple housework, or provide minimal physical care for the children, soon became apparent. Because she wanted it and was nearing the end of her child-

bearing cycle, a tubal ligation was recommended. The slow process of explanation to Mrs. W and her husband was dealt with painstakingly by the hospital social worker and a project physician. To permit Mrs. W to come in to the hospital for this operation, they strongly recommended temporary placement of the children, convinced that the father would not tolerate a homemaker. The welfare center, in full agreement, requested temporary placement from the Child Welfare Division of the Department of Welfare. An admission date was set but postponed because the Child Welfare Division would not accept the hospital's opinion and recommendations.

After one interview, the worker from the Child Welfare Division announced that the father did not want placement of the children. The case was then rerouted to the welfare center for rerouting to the Special Services Division to request a homemaker. A representative of this division went in and was appalled at the state of the home, which had not even the minimum furnishings or equipment. Although some doubts were expressed, it was decided, after a big shopping spree, to send in a homemaker.

On the day of admission, the hospital social worker received a frantic telephone call from Mrs. W to come and straighten things out. That morning, the public assistance worker had arrived; then the worker from the Bureau of Child Welfare, followed by a homemaker and her supervisor from the Bureau of Special Services; and finally a Peace Corps volunteer. Mr. W loudly protested and refused to permit the homemaker to stay. When the hospital social worker arrived, they were all at a noisy impasse. On this interagency home visit, the only person who accomplished anything was the Peace Corps volunteer, who fed and changed the baby.

To describe in detail the subsequent events and continued difficulties with this case would take too much space. However, it illustrates how excessively complex family problems can be further complicated by lack of interagency coordination. While the lack of coordinated social work in this case may border on the absurd, it illustrates dramatically how much we are caught up in interagency autonomy, and how impotent this makes us when we try to provide services to disorganized people.

Reconciling Differences

After such experiences, we became convinced that the project must find a way, with the Department of Welfare, to examine and reconcile our differences in practice, policy, and commitment.

The random sample of public assistance recipients in the project provided a resource of identifiable material. In the third clinical year, we launched at the welfare centers what we call, for want of a simpler title, "teaching-consultative conferences." While the burden of teaching and the initiative came from the project staff, we had much to learn about each other. The purpose of the conferences was to improve services to clients, and to uncover agency policies, practices, and prejudices which impinged upon services to

clients and interfered with coordinated social work and medical care. These conferences were not used as substitutes for interagency conferences involving other agencies than the welfare department.

While the conference technique has often been used in the past, our experimental conferences have two features which distinguish them from the regular interagency conferences. First, they represent a continuous medical and social work effort: the social service coordinator and the same project physician constitute the hospital team which meets regularly with the staff of the welfare centers. The cases are presented and discussed by the physician and coordinator. Other hospital staff members are invited when they have a contribution to make. The second feature is that the welfare centers' case supervisors rather than the medical social worker, cooperate in the choice and preparation of cases. The workers and unit supervisors prepare and present the cases. The medical social worker attends conferences, but for reasons already stated, is not directly involved. Discussion is as free as we can make it at this early stage. Two—at the most three—cases have been presented at each session, with time left for followup. We are now working on an outline for presentation which is based upon the forms used by the welfare centers to evaluate service needs.

Month by month, we have taken a look at these unresolved problems: how to facilitate medical and psychiatric care; how to assess medical and psycho-social disability and set reasonable expectations for the chronically unemployed client; how to assess family problems, and what to do about inadequate parents; how to work together in the evaluation and treatment of behavior disorders in children.

Let us now return briefly to Mr. D, whom we left in a state of anxiety at being asked to prove himself unemployable. He was chosen for one of our experimental conferences.

When we sat down together to discuss Mr. D at the welfare center, we found that neither the public assistance worker nor his unit supervisor had made use of our letter, which had been tucked away in the voluminous correspondence file. The public assistance worker believed that Mr. D's disability was "all in his mind," but had no idea how to get it out. He also felt strongly that this man should work. We learned from him that Mr. D had now settled down in his neighborhood (having found a motherly Italian landlady) and appeared content.

What had we learned so far? Even when the hospital provides medical and psychiatric informa-

tion, it may not always be used to good advantage by the welfare center. In this case the center's orientation was on reclassification, rather than on service to the client. When a new public assistance worker was assigned, Mr. D was treated as a new case whose eligibility was still undetermined. The written invitation to the welfare center to keep in touch with the project went unheeded.

However, when we talked it over, the welfare staff began to understand Mr. D's limitations. They gave up the immediate goal of reemployment. The worker was relieved and reassured about his commitment to the client and his responsibility to the agency. The patient has, since then, used the hospital less for anxiety symptoms. The welfare center has not requested further physical examinations.

Our experience to date has shown that improvement in cooperative work with the Department of Welfare can only be made by recognizing that the invisible curtain which sometimes exists between us is hung in the hospital as well as in the Department of Welfare. Misconceptions and biases about medical care and social work exist on both sides.

The assessment of our experiment to coordinate care and improve working relationships between the hospital and welfare centers is still in process. We are encouraged, however, by the fact that the welfare department sees this experiment as a useful teaching-consultation device. Next year, we hope to incorporate these conferencees into the training program of the welfare centers.

Our casework and project experience with this random sample of public assistance recipients strongly suggests that hospital social workers need to reexamine certain aspects of their practice.

First of all, it raises questions about our established system of referrals. Examination must be made of new sources of caselinding which do not depend wholly upon referrals from physicians. The characteristics of the clients, their ways of coping with stress, and their patterns of response to all disciplines within the hospital will bear careful scrutiny; and so will our patterns of response to them.

We must find ways to categorize the kinds of social dysfunctioning, with or without the presence of serious medical and psychiatric illness, in which we are prepared to intervene. It is also essential to delineate those special problems within the scope of our present practice which stem directly from a breakdown in relationships, maintenance, or services between the client and the Department of Welfare. Such problems may well be handled at a service level



A sick child looks to hospital staff members for affection. Assuring appropriate care for sick children at all times requires effective coordination of public health and welfare services.

by nonprofessional staff, and at an administrative level by those who are in a position to change policy or procedures.

What has also emerged from our experience is proof that our traditional methods of casework intervention are often inadequate. While we are used to working with crises in hospitals, we cannot always find ways to release the energies of public assistance recipients to work on their problems, chronic or critical. Yet we have been effective with some very complicated cases and hard-to-reach clients. I think we would do well to be courageous and look hard at our results, to see if we can find out why we succeed and why we fail. In order to serve more people more effectively, we need to set priorities and learn how to use our skills economically. This calls for experimentation in new social work techniques, such as group treatment or social action groups among clients. We must be prepared to take a stand on current issues which, affecting public assistance recipients and their impoverished neighbors, cry out for social action.

The task is enormous. We cannot afford to close our eyes to the difficulties involved in coordinating social work and medical care for recipients of public assistance. But we need not work at cross purposes if we are prepared to join together to see what is good and effective—and what needs to be improved—to strengthen individuals and families.



THE HOSPITAL THROUGH A CHILD'S EYES

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THE CHILD who is hospitalized enters a strange, sometimes terrifying world. He is under the stress of illness, separation from his parents, and the mystery of a vast, complex, and unknown setting. The experience can be traumatic. Often it produces behavior unusual in the child. The health professions concerned with helping him during this period of crisis need to know more about what he is feeling and thinking: Does he know why he is there, what will happen to him, what is expected of him? Mothers taking leave of their children at the hospital often demand or beseech them to "be a good boy (or girl)." What does good behavior in the hospital mean to a child?

In an effort to learn more about these young patients, their view of the hospital world, and how they learn to function in it, we have interviewed 40 hospitalized children. The children—20 boys and 20 girls—were patients in 2 hospitals in the Boston area: a large general hospital and a smaller hospital for children. Those in the large general hospital had been admitted to the pediatric unit through the outpatient clinic. Those in the children's hospital were under the care of private physicians.

The head nurses helped in selecting the children for the interviews. Physical condition and age were the two important criteria. No seriously ill children

were included. All the children were between the ages of 6 and 9 (mean age, 7.6 years) and thus were in what the developmental literature calls the latency period—a period in which the child characteristically is willing to apply himself to the tasks at hand.¹

All but five of the interviews were conducted during the child's first week in the hospital. Thirty of the children had had or were facing surgery; 29 had had previous hospitalizations. All but two of the children had attended school before coming to the hospital.

The Interviews

At first we established rapport with the children through a small group play session. Immediately after this, the individual interviews began, and, as far as possible, only the interviewer and the child were present. As interviewers, we wore street clothes with smocks rather than nurses' uniforms, so that the children would not confuse us with the nurses providing them with treatment. Because we believe that children may have trouble talking about values in behavior on direct questioning, we used a pictorial approach to elicit feelings and beliefs. The drawings showed:

1. A child approaching the steps of a house, where

a smiling woman with a gesture of welcome is opening the door.

2. A child and a woman talking inside the home.
3. A child and a woman approaching a hospital.
4. A child talking to a nurse in the hospital ward.

In each picture shown to a particular child, the child portrayed was of the same sex as the interviewee. The interviewer began by saying: "I have some pictures here and I would like you to tell me what you think is happening to the little boy (or girl)."

During the discussion of the pictures, the children, with a few exceptions, became relaxed and interested. Then the interviewer went on to ask the direct questions:

• Why do children go to the hospital?

"Because they are sick" was the most frequent answer (19 children). Specific conditions were named by 15 children—broken leg (6), pneumonia (4), cuts (2)—often the conditions for which they themselves had been hospitalized.

"To get better," said 12 children.

"To get fixed up," said three.

Many of the children gave more than one answer to this and the other questions.

To get more information on how the children interpret the intent of hospitalization or hospital personnel, the answers were labeled "positive" or "negative" in intent. Included in the "positive" reasons were such answers as "to get better," "to get fixed up," "to get taken care of," "so the doctor will know what is wrong and then help you."

Fifteen of the private patients gave positive reasons for hospitalization; only two clinic patients did so. Age may have been a determining factor here, since the private patients were, on the whole, older than the clinic patients.

The 9-year-olds were most generally positive (7 of 12); younger children, less so—age 7 (4 of 7); age 8 (only 1 of 10); age 6 (3 of 11).

• What happens to a child in the hospital?

"You get the needles," said 23 children.

Operations were mentioned by 16 children, medications by 10, play by 6, and temperature taking by 5. Also mentioned were casts, polio shots, polio drinks, blood pressure, and anesthesia. Girls more frequently mentioned examinations and medicines than boys; boys, more often operations. Whether or not the child had been previously hospitalized did not appear to influence the responses.

• What does mother mean when she tells you at home to "be good"?

"To help her and do what she says," 25 children said. The majority of these (16) were girls. More specific answers were: "to run errands," 11 children; "to do homework," 10; "to play," 8; "to be polite," 8.

• What does the nurse mean when she says the child is a good boy or a good girl?

"To do what the nurse says," said 21 children. More than twice as many private patients gave this answer as clinic patients.

"To go to bed," "lie down," or "go to sleep," answered 21 children.

"You don't cry," said 11; "be quiet," 11; "take medicine," 7; "eat everything," 7. Other answers: "You help other children"; "play"; "be polite"; "don't play rough." Some individual comments:

"You don't scream when you get the needle or when they take your blood. When they take your temperature, you don't scream." (Six-year-old clinic patient.)

"You don't give her any trouble when she goes for a needle. You let her do it without crying. You go to bed when you are told and you eat when you are told." (Nine-year-old clinic patient.)

"You listen to her and do what she says. You take pills, go to bed and don't be noisy." (Eight-year-old clinic patient.)

"You obey and try to get better." (Eight-year-old clinic patient.)

"You don't bother the nurse. Don't interrupt her." (Nine-year-old private patient.)

"You keep out of the nurses' way." (Nine-year-old private patient.)

• How did you find out how a good boy or good girl should act in the hospital?

"I just knew" was the most frequent answer (14 children), especially among private patients (11) and boys (10).

"Mother told me" came next in frequency, and came mostly from girls (11).

"The nurse" was given as the source of information by eight children; both mother and father by six. Five of the younger clinic children said they did not know how they found out. Some comments:

"I know because I'm smart." (Eight-year-old clinic patient.)

"From my mom. She yells at us and tells us to be good." (Six-year-old clinic patient.)

"When you are a baby you can start to learn from your mother and father." (Seven-year-old private patient.)

"When a lot of little kids screamed, the nurse said they are

not good, so I learned that way." (Eight-year-old private patient.)

"Just know. I was always good when I went to the hospital, so they wouldn't get mad at me." (Nine-year-old private patient.)

"Your mother and father teach you manners and how to act." (Eight-year-old private patient.)

At the conclusion of each interview, a notation was made as to how much at ease and how comfortable the child had appeared when reacting to the pictures and answering the questions. Of the total, only seven children (four, age 6; one, age 8; and two, age 9) did not respond freely. Six of these were in the clinic group. The children in the private setting, although responsive, seemed more anxious to please and to give the "right" answers. They seemed more prone than the children from the clinic to look for clues in the behavior of the interviewer which would indicate approval or disapproval. For the most part, the children did not seem to mind having their remarks recorded; some of the 8- and 9-year-olds seemed pleased.

Some Implications

These responses indicate that parental admonitions to "be good" in the hospital seemed to have definite meaning for the children we interviewed. They saw their roles this way: to conform in behavior, to be quiet, not to resist treatment, to keep out of the way of nurses and doctors. As one 8-year-old said: "You let them do what they want to you. You do as the doctors and nurses say."

In general, the children said they had learned mostly from their parents what behavior was expected of them. They also reported learning by observing the nurse-patient interaction within the pediatric unit. Few mentioned the influence of their peers. Most of the children gave realistic reasons for children's being hospitalized. The older the children, the more likely they were to give a more positive interpretation of the intent of the hospital personnel. The 6-year-olds had the most negative attitudes, as would be expected from studies indicating that young children view hospital procedures as intrusive.¹ More than half the children associated the hospital with "needles"; age did not influence this reaction.

Thus it seems that a child in the latency period views the hospital as a place where children go because they are sick and want to get better. In the hospital, children receive passively and without question the needles, operations, examinations, and medication that nurses and doctors deem best for them.

The whole situation seems to resolve itself into one of passive conformity, in which there is little if any possibility for the patient to participate actively within the environment. The child senses that his fate has been predetermined by others, and that he is being acted upon rather than participating as an actor.

There seems to be a marked similarity in the way children and adults see acceptable behavior in a hospital setting. Adults have described good behavior as being submissive, noncomplaining, and following the rules and orders.² The children we interviewed apparently learned early the value of conformity in the hospital. At their stage in life, they have undoubtedly also been receiving from adults at home and in school, considerable pressure to conform. Thus, developmentally, a tendency on their part toward conformity could be expected.

The question arises, however, as to how much pressure toward conformity may be necessary in a hospital pediatric unit and how much is therapeutic or the opposite. One wonders how much conformity children of this age can tolerate without having it seriously affect their emotional growth. If there is a danger point in conformity, then the longer the interval of hospitalization, the greater the hazard to normal growth and development.

The school has built-in outlets for the child's need for motor and vocal expression. Afterschool activities, the daily play period, and the annual vacation furnish further outlets for such expression. Many pediatric units, however, are only beginning to provide play programs and other planned recreation.

However, beyond the need for outlets for expression, the child of latency age needs to win recognition by being productive. Could the hospitalized child's desire to please be used in a more constructive manner? Is he ready to learn more about health and health practices during his stay? No child mentioned "learning" as "good behavior" in the hospital. Hospital personnel do not seem to have capitalized on the desire of children in their care to learn to do things well. Nor have they exploited the willingness of the child of latency age to practice in order to become proficient. Surely these are ways in which the hospitalized child who is not seriously ill might be helped to function more productively.

¹ Erikson, Erik: *Childhood and society*. W. W. Norton & Co., New York, 1950.

² Coser, Rose Laub: *A home away from home*. *Social Problems* July 1956.

A PRESCHOOL PROGRAM FOR CHILDREN WITH CEREBRAL PALSY

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WHEN A CHILD with cerebral palsy approaches nursery school or kindergarten age, the question which confronts parents, doctors, school officials, and everyone concerned is: Will this child ever be eligible for schooling? The eligibility of the child, in most cases, depends on several factors: achievement on a standard intelligence test, degree of physical involvement, ability to communicate or take care of his own toileting needs, and chronological age.

The entrance requirements placed on disabled children by many schools or kindergartens are much greater than those for normal children. Children who show no obvious disabilities need only to show proof of age to enter school, whereas children with known disabilities often have to meet rigid requirements.

Children whose physical maturation is retarded develop more slowly than others in such areas as ambulation and speech. Such children are known to perform poorly in tests in their preschool and early grade school years. Any child whose backlog of experiences and information deviates greatly from the normal child's will perform below par on a test which is designed for children who have had "normal" experiences for their age.

One should not expect a child who perceives the world about him differently than others do to gain

the same experiences and information from his environment and react to it in the same way. Because some authorities do expect this, some children with cerebral palsy are excluded from schooling without being given a trial.

To give such children a chance to learn, the Cooperative Pre-School Center of the Cerebral Palsy Association of Western New York, Inc., considers for entrance any child between the chronological ages of 3 and 7 who has been diagnosed medically as having cerebral palsy.

All children are interviewed by the principal before entrance, but only a few conditions may cause a child to be excluded. This happens when:

- The child appears to have no response to his surroundings. (Responses need be only with his eyes.)
- The child is unable to move about on the floor in any manner.
- The child is very immature. Exclusion may in this instance be only until he is a year older.
- The school has reached capacity enrollment. In such instances the child is placed on a waiting list.

Any child who is not accepted by the nursery school can enter the day-care program of the Cerebral Palsy

Association of Western New York when he is 5 years old. This is purely a recreational program.

Our liberal screening policy is based on the realization that several factors can hinder a child's development. These are lack of proper stimulation, unfortunate parental attitudes, mishandling of the child, and lack of knowledge about cerebral palsy on the part of parents and family members.

We have found that many children can exceed what they are initially thought capable of doing, when they are taken out of their familiar surroundings and placed in a nursery school where they experience understanding and patience, are guided in play, and receive training in visual, tactful, and auditory perception.

All children who are admitted to the Cooperative Pre-School Center are on a trial period for 5 months. The child is allowed to remain longer if, by that time, he shows progress in any one of the following areas:

- **Physical:** (a) self-care; (b) ambulation; (c) manipulation; (d) toileting; (e) feeding.

- **Social:** (a) group participation; (b) ability to get along with others; (c) sharing.

- **Emotional:** (a) self-discipline; (b) self-control (control of temper tantrums); (c) ability to take changes; (d) ability to respond to criticism and suggestions; (e) self-confidence.

- **Educational:** (a) visual and auditory perception; (b) attention span; (c) varied experiences and types of learning—art, music, and free and purposeful play; (d) communication.

Over the years, we have found that toilet training, awareness to surroundings, ability to handle materials, and means of communication can be improved through guided experiences.

Toilet Training

There are many schools where children are excluded if they are unable to communicate their need to go to the toilet. The reason for making toilet training a prerequisite for schooling is based on the fact that most children attain toilet training by the time they are 2 to 2½ years of age. "If a child is not toilet trained," it is argued, "he has not reached a mental age which would indicate readiness for preschool."¹

The preschool staff of the Cerebral Palsy Association believes that this concept is not applicable to all children with cerebral palsy. Some children with this affliction have difficulty controlling rectum and

sphincter muscles. Moreover, some children are unable to sit on a toilet seat, a fact which in itself could delay toilet training. To exclude a child for either of these reasons would be a great injustice to him.

True, some children not emotionally or intellectually ready for toilet training are likely to achieve it at a later age. However, even these children in many cases can profit from other areas of training offered by the school.

The results of a survey of children who attended our preschool program between 1955 and 1960 indicate that we have had reasonable success in toilet training. Part of this success may be due to the fact that many children have less difficulty learning in a group situation than in individual training. But whatever the reason, the results of the survey showed that, of 81 children who either were not toilet trained (77) or about whose toilet training there was some uncertainty (4) when they were admitted to the nursery school, 56 became toilet trained before they left the school.

Intelligence

Besides toilet training, achievement on a standard intelligence test is used in some nursery schools as an entrance requirement. The accuracy of these tests depends on many factors: the rapport between the tester and child; how the child feels; the child's attitude at the time of the test; and the child's ability to respond in an acceptable way. The last factor can be crucial, since many children with cerebral palsy have trouble communicating. In some cases the child's speech may be so unintelligible and the physical involvement so great that testing does not give a true picture of his intelligence. Factors such as these can make a test score lower, indicating a lower potential than the child actually has.

Persons working with children with cerebral palsy soon learn that these children need help in acquiring many basic experiences that normal children acquire on their own. For several reasons a cerebral palsied child's learning at home may be hindered. This may be due to the parents' allowing or even encouraging their child to become dependent because they do not have the time or patience to help him achieve in activities of everyday living. Many parents are overprotective or underestimate their child's abilities. Other parents overestimate their child's capabilities or are hostile to the child because of his handicap.

Many children when removed from their home environment for part of the day have a tendency to gain a greater degree of self-confidence and physical

and emotional independence, thus making it easier for them to try activities which will help their development. Until a child loses some of his apprehension about new situations, his learning will not be up to his potential.

Many children have had a rise of 10 or more points in their IQ score while they were in our preschool program. This may stem from the fact that the program has provided them with many new guided experiences they did not have at home.

A Typical Day

A typical day in one of the program's classes would consist of—

1. Learning the skills needed to undress. Each child is taught how to take off his hat, coat, rubbers, and the like, with as little help as possible.

2. Free play—a period when the child is allowed to pursue one of many possible activities on his own. If the child is confused by this freedom, the teacher gives him a choice of two activities which are within his capabilities.

3. A group activity which is planned to help each child cope with his limitations and to develop social skills, such as sharing and taking turns. The group activity is also planned to help the child develop one of the following capacities: auditory, visual, tactful, or taste discrimination; hand-eye coordination; recall; and recognition.

4. A milk-and-cookie period. The child is encouraged to feed himself and use proper table manners if possible.

5. Nap time. Music and songs are played.

6. Active group play. The children are taught group games, starting with simple games like "ring-around-the-rosy," and working up to games which call for creative and imaginative play.

7. Quiet activity, such as listening to a story or playing guessing games.

8. Learning to dress while preparing for departure.

Each child attends the school for 2 hours a day in a class of 6 to 12 children who tend to have problems similar to his own; and, in spite of the time limitations, each child receives individual attention from the teacher during a free play period at least once a week. At this time, the teacher's aide watches the other children.

While class activities are planned around the group, the wishes, likes, and dislikes of individual children are also taken into account. The program is structured only as a means to an end—to help each child to become all he is capable of becoming—and its essence is flexibility.

Under this type of program most children in the preschool program seem to gain benefits from it even if they are not toilet trained or trainable. Many make great strides in all areas of development while

These pictures show children and teachers in the preschool center of the Cerebral Palsy Association of Western New York. At left: children in various stages of learning to dress. At right: preparing flour clay for use in a free play period.



there. While the school cannot take all the credit, its efforts in many instances may have made the difference between the child's acceptance or rejection later by a public school.

Moreover, while a child is in nursery school under the watchful eye of a trained person, other problems often come to light which have not previously been noted—for example, hearing losses, visual problems, or other symptoms of brain damage. The trained teacher by seeing the child 2 days or more a week in many varied situations is in a good position to observe signs that indicate such disabilities. Such observations lead to further inquiry and, if necessary, the child is recommended for further checking by appropriate specialists.

The majority of our children are recommended to us by the Children's Hospital Rehabilitation Center in Buffalo, N.Y., with which we work very closely. This center has facilities for evaluation and treatment through speech, occupational, and physical therapy. If our preschool staff have questions about an aspect of the development of a child recommended to us by the center, we can recommend that the child be tested there again.

The Severely Handicapped

The degree of physical involvement plays a lesser role in screening for public school entrance than the degree of measurable intelligence. Many schools will accept a child with a severe physical handicap if he has a normal or better IQ. The child who is really hurt is the one with severe cerebral palsy who scores below 50 on an intelligence test. He is not eligible for a school for the physically handicapped, nor is he eligible for a public school class for trainable children. His only resource is a day-care program, and there may not be one in his community.

We accept children who are severely handicapped physically, regardless of their IQ, if they seem likely to receive any benefit from the program and meet the requirements already mentioned.

We have, for example, a class of six children, ages 3½ to 6½, every one of whom is in a wheelchair and is almost completely dependent. Their intelligence falls in the "trainable" and "educable" range.

Even in the short span of 5 months, we have been able to help each of these children in some way. Most of them in the class were trying to use their hands more; two were learning to feed themselves a cookie and handle a cup. Every child was trying to play

ball with the group and to follow simple directions. The majority were understanding more words the they did at entrance.

If these children lived in an area of the State in accessible to our school, they might have no school training and thus no chance to play and associate with others, or to meet and experience new situations. Most of the children in this class have very little chance for achievement outside of school. If it were not for the school, they would not have had some of the following experiences:

- Field trip to Lake Erie to see the boats.
- Petting a small 5-week-old puppy and helping to mix its cereal. (Giving the child a chance to help and to learn that others need help too.)
- Helping to mix the ingredients for fudge. (Giving each child a chance to become more aware of his senses by tasting and smelling and feeling all the ingredients and the finished product.)
- Playing, achieving, and being with others in a group. (Learning social skills.)
- Handling art materials and making things with them for themselves and others.

Through providing these and many other experiences, we have helped the children to be less demanding, to have some (if only a little) idea of how it feels to help others and to do for oneself, to enjoy being with other children, and to play by themselves. Most people take such experiences for granted, but, for handicapped children, they are not within easy reach.

Our preschool staff has never regretted the program's liberal screening policy. Even when we have not been able to help a child, we have usually been able to help his parents. Through parent-teacher conferences, many parents have learned to understand and to accept better their child's limitations.

If we are asked to define our policy toward admission, it would be: that until the child has had an opportunity to fail, we really do not have any basis for rejecting him from preschool because of what we believe are deficits. We try never to forget that a handicapped child is a child first, and that the inconveniences to adults of a liberal screening policy are greatly outweighed by the benefits to the child.

¹ Reaume, Virginia Thomas: Toilet training as a prerequisite for admission to a cerebral palsy preschool. Cerebral Palsy Association of Western New York, Buffalo. 1964.

WORKING WITH CHILDREN WHO WON'T GO TO SCHOOL

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THE ATTENDANCE officer of 30 or 40 years ago would have trouble identifying his job today. At that time, he had a rather simple, well-defined function: to get truants back to school. And truants in those days seemed also to be less complicated individuals. They truanted because they wanted to go hunting or fishing, needed to work to earn extra money by harvesting crops, or just did not like school and preferred to learn a trade. By and large, truants were not very hostile toward school and authority, and truanting even had its own ground rules, which both truant and truant officer observed.

In contrast, the attendance worker of today, who in some school systems is the school social worker, has a very complex job requiring him to deal with a wide variety of chronic and severe social and emotional problems.

At its simplest, the job involves dealing with youngsters whose families are economically and socially deprived and more concerned with keeping food in their stomachs than with schooling. Many of these children have severe learning problems because education is neither valued at home nor presented to them in their overcrowded classrooms in such a way as to give them the experience early in life of some of the fun and satisfaction that can be derived from achievements in learning.

Many of these children live in broken homes, or with parents who have been terribly defeated by the

difficulties of living and, therefore, have given them little of the vital ingredients of nurturing. Such youngsters learn at very early ages to fend for themselves and to grab the pleasures of the moment, because only the moment counts in such drab and joyless existences. They resent and even hate any adult authority figure who interferes with their pleasures.

School for many such children provokes anxiety. Learning requires effort, patience, and perseverance, especially to learn enough to begin to get some pleasure out of the process. Early in their school experience, these youngsters react with increased restlessness to the teacher's insistence on learning. They escape into daydreaming or loud, provocative, hostile behavior. Removing themselves from the classroom via disturbing behavior may become an escape mechanism for them. In high school, they are among the nonreaders and nonlearners who can find no interest or purpose in school. Many turn to delinquent activities. They truant to get their "kicks" with age mates outside of school. Since they see no future ahead, no job, no security, no real purpose in living, today only is important.

Emotionally Disturbed Children

Another group of children encountered by schools with increasing frequency today are the children whose emotional disturbance is manifested through psychosomatic illnesses that keep them out of school

or through school phobia. In either case, the parents are usually intimately involved with the child's difficulties. This is perhaps most evident in cases of school phobia. In such cases, the mother usually feels great anxiety about separation from her child, who has provided most of her emotional satisfactions—satisfactions she cannot get with her husband. The child in turn reacts to the separation with marked anxiety, fears, and somatic complaints. The father generally is either passive and not very concerned about the child, or resents the child-mother duo that freezes him out. His hostility or indifference often tends to further cement the neurotic, symbiotic mother-child relationship.

The child with severe psychosomatic illness—asthma, allergies, colitis, ulcer, or even rheumatic fever—may be reacting to rather severe emotional problems in, and between, his parents, problems which have deprived him of important love and attention. The present illness gains for him at least a good deal of attention and concern, however ambivalent that concern may be.

In all of these instances, the attendance worker is confronted with disturbed and often hostile parents who unconsciously feel attacked by any discussion of their relationship to the child. These parents usually resist the worker's efforts to get the child back to school.

Yet another kind of child is the schizoid, the lonely, introverted daydreamer who tends to leave school because it frightens him. He often wanders the streets alone or sits alone near the school. He is clearly not delinquent or involved with gangs. The parents of such children are often severely disturbed people who feel rather helpless and hopeless in dealing with their child as well as guilty about their disturbed relationship with him. They frequently deny that the child presents a problem.

Helping the Parents

The worker's efforts to help youngsters stay in school involve not only conferences and work with the child, but also, and increasingly, efforts to help parents. It is around these efforts especially that referrals to social agencies and consultation with mental health professionals are sought.

Of what value are short-term efforts to help disturbed, defensive, concerned parents? The most hostile parents are those whose troubles have been so great that they have felt defeated in most areas of living. They have been unable to concern themselves much with their children and are disturbed, dis-

traught, and helpless in the face of the child's anger and demands, or his predelinquent and delinquent activities. They want others, especially the school teacher or administrator, to act as a parent to their child and to change him into a useful, cooperative citizen.

Any demand upon them to deal with their child more effectively as parents, to be more responsible and more firm, results either in greater helplessness and anger with school personnel or in hostile, retaliatory, punitive, often sadistic action toward the child, without effecting much change in his behavior. It is difficult to help such a parent even with prolonged psychotherapeutic work. What, then, can a few interviews do?

Surprisingly, the attendance worker who can openly recognize what a difficult spot the parent is in with such a child—a child who responds to neither cajoling nor punishment—may be able to get the parent to understand how important education is for his child's future, how important for keeping the child from becoming as stuck and helpless as the parent himself now feels. This realization may come from a discussion of the opportunities that may be lost to the child who cannot read or who cannot sustain interest in tasks long enough to complete them.

An emphasis on the importance of the parents' interest in the child's schooling sometimes gives the parents a new sense of their worth and importance to their youngster. Joint interviews held by the worker with the defiant, sullen adolescent and his hopeless, angry parents sometimes give each a different view of the other and their underlying, usually unexpressed, concern for each other. After such an interview, I have heard both adolescent and parents say that they had not known that the other really cared at all. Thus, occasionally, one may help in even seemingly hopeless parent-child relationships.

Parents of phobic or psychosomatically ill children are tied to them by bonds of emotional conflict. It is important to support their efforts to understand and recognize what is best for their child, so that they can feel like good and effective parents. Thus, when the worker does not blame a parent for the child's absences from school—being blamed usually arouses parental resistance and hostility—but instead outlines the parental task necessary to help the child, he begins to reduce the parent's feeling of guilt. Then he can help the parent understand why going to school is important to the child's sense of mastery over his fears.

The emphasis on gentle firmness and persistence

for long periods of time may help parents not to be punitive out of a sense of their own helplessness and guilt. Often such help requires a step-by-step analysis of what the parent needs to do, and how the child may react to each of his moves so that the parent can understand and anticipate the child's reactions to the efforts to return him to school. Parents who are warned that the child may respond with increased illness or hysterical outbursts may be better able to withstand these difficult moments and stand fast on their insistence that the child go to school. The worker's readiness to meet with parents at moments of impasse is often of critical importance in bringing about a successful outcome.

With parents who deny the presence of disturbance in a schizoid child, there is a very serious impediment to communication. Often to get through to them requires repeated efforts by many people who know and express their concern about the child's illness. Sometimes only court action ordering a period of hospital observation for the child will activate the parents to seek help.

Use of Authority

Often, frequent interviews over a long period of time are necessary to help children with school attendance problems. However, even when the contact is brief, the worker has to help the parents to get to know him not as an authoritarian and hostile authority, but as a concerned and understanding professional person who uses his lawful authority in a benign but firm way to help both child and parents with their mutual problem.

The worker's authoritative role, his efforts to enforce the compulsory attendance law, and his potential use of a court hearing, can in many instances be helpful and therapeutic. Frequently, parents of children who truant or suffer from school phobia are unable to behave toward their children with any consistent parental authority. They permit their child to cajole them into overlooking serious misdeeds, and then, feeling guilty, punish him for trifling infractions. Or they seem to let their whim decide the issues. Or, needing desperately to be liked by their child, with whom they have a strained relationship, they excuse his truanting or other unacceptable behavior. Some parents seem to feel that being lenient about recurring misdeeds may make the child appreciate their kindness and so give them a hold over him. Occasionally, parents identify so closely with their child's defiance of authority that they are unable to be authoritative themselves.

The effectiveness of the worker's authority can only come from its judicious and consistent use. The worker must not give the child or the parent another experience of the kind of ambivalent, capricious use of authority the parents have exhibited. Such a use of authority ends in exasperation and the imposition of vindictive measures and makes impossible any real respect for authority. Through the methods he uses to enforce the law, the worker may present an example of how authority may be used with firmness and kindness to accomplish the task of returning the child to school.

Psychiatric Consultation

The ever-increasing caseload and severity of the problems presented have in many instances led attendance workers to try to use psychiatric consultation as one way of helping them cope with problems. However, the worker's relationship with mental health consultants can sometimes be rather strained. The worker may be expected by the school to deal effectively with all of these difficult problems although he knows that even the mental health expert is often not successful. Thus he may feel that to call in a consultant may mean to others that he has failed or lacks competence. When regular consultation is not available to help in the treatment plan, the consultant is apt to be called in only as a last-ditch effort to solve a problem.

As also happens in medical consultation, the mental health consultant is then expected to have the expert knowledge and special magic to solve the problem. Often, however, he has no magic and his suggestions are not new to the worker, who has already considered them. Therefore, the worker sometimes feels angry and disappointed because he has not been helped, while at the same time he may feel secretly pleased that the expert has not come up with much more than he did. His anger is always partly justified if the consultant has not been able to help him see that one value of consultation is the *sharing* of responsibility about difficult problems so that the worker will not feel alone and burdened by them.

As workers gain experience as participants in consultation, they learn that although the consultant's ideas and suggestions are often not new or even very effective, they tend to help the worker clarify his own thoughts and encourage him to try out ideas he has entertained but has been wary of attempting.

The consultant can be helpful to the worker when it is necessary to refer the child and his parents to another community resource for service. He can

help not only in determining what the appropriate resource is, but also in assessing the probable length of time it would take to bring about the desired change. This latter assessment can be helpful to the worker in dealing with school personnel who are apt to expect altered behavior in the child promptly after referral and are disappointed and angry when it is not forthcoming. School personnel frequently need help in understanding the gradualness of change and how the attitudes of the school teacher and administrator toward the child's need to learn can help bring it about.

Preventive Role

How can the attendance worker be a more effective member of the school mental health team? This is a touchy problem. The worker tends to be used in a variety of roles in the school. Sometimes he is a leg man for the administrator. Often, referring a long-term truant to him is one last effort before an expulsion or suspension already predetermined in the administrator's mind, thus allowing him little opportunity to work with the child and his parents. In some instances, the worker, without having had any contact with the child or parents, is told to take the case to court.

The preventive function of the attendance worker is rarely called upon. He is not often included as part of the school team of administrator, teacher, and school nurse which evaluates children whose behavior and learning difficulties indicate that they may be potential truants. He is rarely asked to work with such children and their parents early in the difficulty or early in the child's school experience.

Thus in each of his cases the worker has the dual job of apprising the school personnel of what might have been done had the child been referred to him earlier and of demonstrating how the teacher may help keep a child in school by giving more attention to his learning problems and calling on the attendance worker to work with his parents.

Adult Models

In working with truants, the worker must keep in mind the kind of models these youngsters need in the adults around them—grownups who are neither punitive nor patsies, whose understanding of children leads them to be firm, fair, and consistent in their attitudes, realistic in their evaluations of the child and his situations, and hopeful about a human being's ability to change. These youngsters need to experience adults who, unlike their parents, neither

fool themselves nor are conned by a child's false promises. They need a person who is convinced of the importance of the child's remaining in school and who, at the same time, realizes the difficulties for the child and teacher in getting any learning started, caused by the obstacles in the child's home environment and the grim realities of today's crowded classrooms. Such conviction and reality assessment, when communicated to children and teachers, sometimes begin to help them to try it again, and perhaps again, and to stick to it a bit longer each time.

In the case of the phobic or psychosomatically ill child, the worker needs to adopt a determined persistence with child, parent, and school so that the child will begin to feel in his bones that he has to go to school, that, if necessary, he will be taken to school. Only consistent authoritative efforts help both the child and the parent who has abandoned the authoritative parental role.

The prepsychotic, schizoid youngster desperately needs psychiatric help. Sometimes the worker's awareness of the problem and his sensitivity to the youngster's needs provides the child with valuable stopgap attention until his parents are able to seek aid from a clinic.

In Conclusion

For an attendance worker to use a mental health consultant is *not* a sign of inadequacy and incompetence. On the contrary, it reveals mature thinking designed to make a difficult job more manageable.

The consultant's function is not only to supply some insights from his particular field of work, but also, and most important, to provide a noninvolved, fairly objective perspective toward problems. Often, solutions can be found by the worker once problems are discussed from a new vantage point.

The attendance worker, in turn, has certain obligations to the consultant: (1) to educate the consultant about the worker's job, so that he understands what and how the worker functions, what pressures the worker is under, and from whom; (2) to help the consultant understand the school setting more fully, the people involved, and what they contribute to the child's, parents', and worker's problems; (3) to learn to use the consultant well—to assess the kinds of problems the consultant is most helpful with, and to see if, together, worker and consultant can learn to collaborate more effectively on the others. If the worker carries out these obligations, he will be helping the consultant to grow into a more helpful colleague in the venture of keeping children in school.

CROSS-AGE RELATIONSHIPS— AN EDUCATIONAL RESOURCE

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AT THE INSTITUTE for Social Research, University of Michigan, we have begun to probe into areas of relationships between children of different ages.

Over the past 3 years, we have carried through a series of pilot projects in two elementary schools—first in the University of Michigan laboratory school and later in several biracial classes in a public school in a neighborhood of blue-collar workers—and in a summer day camp for boys and girls from 4 to 14 years of age.

In these pilot projects, we have attempted to determine what is required to implement a constructive program of cross-age interaction; and have begun to collect data on, and evaluate the impact of, the perceptions children have of other children who are older and younger than they are.¹

The process of educating children can be divided into two interrelated parts:

1. A process of socialization, whereby the child learns, internalizes, and practices certain patterns of values, attitudes, and expectations which have important implications for his behavior.

2. A process of subject-matter learning, whereby the child acquires and learns to use information and

problem-solving skills to achieve some degree of mastery over the major domains of knowledge.

In our society today, the major responsibility for helping children acquire the skills, attitudes, and values necessary to function successfully as adults has been placed in the hands of parents and educators. This model of a few adults and teachers working with, and being responsible for, such a complex learning program presents serious difficulties. There are limits to the amount of individualized attention the learner can receive when the major weight of all learning transactions is placed on the relationship between adults and a large group of youngsters.

We may not be making the best use of the powerful potential educational resource represented by cross-age relationships among children. It is an observed fact that children, with proper training and support from adults, are able to function effectively in the roles of helpers and teachers of younger children—and that the older children find this type of experience meaningful, productive, and a source of valuable learning for themselves.

Most children are involved from a very early age with older or younger siblings, or both. In preschool neighborhood life there is usually a variety of significant cross-age relationships. Cross-age interaction is probably a potent learning experience for children of all ages.

For instance, a child observes how children older

The pilot projects on which this paper is based were supported in part by a grant from the U.S. Office of Education (Cooperative Research Project E-011).

than he cope with adults; what the older ones are able to do; what they are permitted to do; and the fact that children younger than he seem to get more attention from adults. Furthermore, he learns how to cope with, or avoid, the greater strength and sophistication of older children; to exploit the younger ones; and to avoid the sanctions of adults for mistreating children weaker than himself. He learns that his age-graded classmates are supposed to be regarded as his equals. He develops his conceptions and expectations about the different levels of "grown-upness," and what they mean in terms of privilege, responsibility, and skills.

Five Assumptions

One assumption underlying our pilot projects has been that much of the process of socialization involves use by younger children of the behavior and attitudes of older children as models for their own behavior. This process has great potentiality for planned development as an effective educational force, provided that children are trained appropriately for their roles as socialization agents.

Some of the important natural components of this cross-age modeling process include: an older child's ability to communicate more effectively than adults at the younger child's level; the fact that an older child is less likely to be regarded as an "authority figure" than an adult would be; the younger child's greater willingness to accept influence attempts when he perceives a greater opportunity for reciprocal influence; and the fact that a slightly older child provides a more realistic level of aspiration for the younger child than an adult would.

A second assumption of our projects has been that involvement of older children in a collaborative program with adults to help younger children will have a significant socialization impact on the older children because of (1) the important motivational value of a trust- and responsibility-taking relationship with adults around a significant task, and (2) the opportunity to work through—with awareness but at a safe emotional distance—some of their own problems of relationships with their siblings and peers.

A third assumption has been that assisting in a teaching function will help the "teaching students" to test and develop their own knowledge, and also help them discover the significance of that knowledge.

A fourth assumption has been that both younger learners and their adult teachers will be significantly helped in "academic" learning activities through the

utilization of trained older children available for tutoring, drilling, listening and correcting, and other teaching functions.

A final assumption has been that a child will develop a more realistic image of his own ability and present state of development, and will gain a greater appreciation of his own abilities and skills, if he has an opportunity to help children younger than himself to acquire skills which he already possesses and to develop positive relationships with children older than himself.

Children's Perceptions

There is a circular process in cross-age interaction. The feelings and attitudes of the older child affect both his intended behavior toward the younger one and his expectations and perceptions of the younger child's behavior toward him. At the same time, the way the younger child sees the older child's actual behavior is evaluated by the younger child and, combined with his other attitudes, affects his attitude and his intended and actual behavior toward the older child. Then the younger child's behavior, as perceived by the older child, produces feedback (information which enables the older child to compare his expectations of the younger child's reactions to his behavior with the actual effects of his behavior on the younger child), and this further influences the older child's attitudes toward the younger child.²

In response to questions asked in our pilot studies, children discussed their perceptions of children older and younger than themselves.¹

In general, we found that both boys and girls perceive older children (called "olders" in our project) positively when the olders include them in their activities, or are friendly, or offer help or recognition. On the other hand, the younger children ("youngers") appear to have a great deal of ambivalence in approaching olders, whom they so often perceive negatively as exploitive, hostile, or domineering. Considerable distrust is engendered in these relationships because the olders typically perceive the youngers as incompetent, and exclude them from rewarding patterns of interaction.

Boys, particularly, perceive younger boys to be incompetent and demanding too much of their time and resources. On the other hand, boys perceive youngers positively when the youngers are competent enough to participate in activities that the older boys like, or when the youngers will help them or submit to their influence.

Older girls, on the other hand, appear to experience

youngers positively as objects for nurturing; or negatively, as teasing and demanding too much attention.

These perceptions, we believe, tend to reflect experiences encountered and attitudes and values learned as the child is socialized into his appropriate sex role in our culture. When such patterns of attitudes and expectations have ambivalent or negative components, they tend to discourage any tendency toward interaction among children of different chronological ages or developmental levels. Simply providing opportunities for children of different ages to interact, therefore, is not a sufficient condition for the development of growth-supportive patterns of cross-age interaction.

What is needed is a program of education or training, providing opportunities for children to gain insight into their own attitudes and those of others; a chance for them to practice skills of giving and receiving help; and the development of situations making it possible for them to examine and understand the consequences of their own behavior on the behavior of others.

Therefore, we have designed a plan for such a program. This draws mainly upon our experience in the two schools—the university laboratory school and the biracial public school. We believe, however, that each of the program elements we have outlined for the school have parallels in other settings.

Program Elements

In our school pilot projects, sixth graders were involved as academic assistants in the fourth, third, second, and first grades. They helped children in the younger classrooms with reading, writing, arithmetic, spelling, and physical education. In addition, they were used as laboratory assistants in social science laboratory periods, working as group-discussion leaders and producing "behavior specimens" presented for observation and study.

Their success was the result of several carefully planned steps in the development of collaborative cross-age interaction.

1. Providing opportunities for cross-age interaction through collaboration between adults.

First, the project coordinator and the teachers involved in the project held an orientation session to discuss the opportunities the program could offer, not only for the growth and development of positive relations between the children of different ages but also between the teachers of different grades.



"... a child will develop a more realistic image of his own ability . . . if he has an opportunity to help children younger than himself to acquire skills that he already possesses. . . ." Here a sixth grader helps a younger child with his lessons.

The project was presented as one in which no teacher was giving up his authority over his class, but rather was lending the resources of his children to benefit both youngers and olders individually—and each class collectively. The concerns each teacher had for his own class were discussed, as were ways in which the project might help his children reach their individual goals, and, in addition, help the teacher to reach his goals for the class as a whole.

The project staff then met weekly for planning, discussion, and evaluation. A schedule was developed for times during the school day when the helping children, five or six in a squad, could be trained in skills of relating to younger children, also in skills in the teaching of content material; periods when the helpers would be in the youngers' classrooms; and periods when the teachers could have discussions with the student helpers about their pupils' progress.

2. Teacher-student collaboration.

Teachers then explained the purpose of the project to the sixth-grade classes. There was discussion of how difficult it is for one teacher to give a great deal of individual help in her classroom. The role of the older students in the project was described in terms of the unique contribution which these students could make in helping younger children to learn.

In this and subsequent meetings, an attempt was made to develop a partnership between the teacher and each helper which would encourage mutual par-

ticipation in goal-setting and the planning of strategy.

3. Building a peer-group attitude which supported the value of helping youngers and being helped by olders.

One significant aspect of child life which tends to prevent constructive relationships between older and younger children is the fact that in the usual peer culture of children, no status can be gained by treating youngers with anything but hostility or avoidance, coupled with the resulting assumption of the younger children that older children do not like them and cannot be trusted.

In order to change this state of affairs, which may not be enjoyed by either group, it is necessary to build within both older and younger classes of children an influential peer group which looks upon the idea of giving help as an attitude producing status and rewards.

This was done in our project by putting children held in high regard by their peers in the first two groups of sixth graders to be trained to relate to younger children; and by having the training and briefing of these children given at such a time and in such a way as to establish clearly that some glamour was connected with it.

In addition, a panel of four of the seventh graders with high peer status, who had had experience in the sixth grade the year before as trained helpers with the junior kindergarten, talked to the sixth graders about the advantages that they had perceived for themselves in this helping relationship. They taped this talk to be used for the sixth graders who were going to be helpers in the other school. The seventh graders also made and taped a different talk for the fourth graders, explaining to them the advantages which the fourth grade would be giving the sixth grade in allowing the sixth graders to help them. This was to show the younger children that the help was not just one-way: that the fourth graders had much to contribute to the older group which the latter might never get in any other way.

4. Training for the helper role.

These first two groups of helpers from the sixth grade, and subsequently the other members of the sixth-grade classes, were carefully trained in how to relate to younger children, and briefed in their specific jobs. This was accomplished through—

Seminars. Here the olders learned, through discussion and role-played episodes, how to approach

youngers constructively, and how to help youngers to accept instruction. They learned what levels of expectation were realistic for children of a particular age, and for the individuals they were to help. They learned the techniques of correcting errors in encouraging, rather than discouraging, ways. They practiced giving praise without lowering performance standards. They practiced methods for taking youngers from the levels at which they were successful to higher levels.

Training in academic procedures. After the older children had had some orientation to younger children, they had a training session with the teacher whom they were helping. The teacher explained how the drill—or whatever she had planned for the older to give—would help the younger children learn. She explained to the olders how they were to carry out the assignment; and, to see if they understood the method and procedure before teaching a younger child, gave them practice in working with each other.

Feedback sessions. The older helpers worked 2 and sometimes 3 days a week with the same child for consecutive weeks—each session lasting from 20 to 30 minutes, depending on the age and attention span of the child being tutored. Before beginning the second week, each helper had a feedback session with the teacher of his child to report what progress had been made, and to get an assignment for the next week's sessions.

5. "At-the-elbow" help.

When the helper met for the first time with the child he was going to help, a teacher was nearby to give him "at-the-elbow" help if needed.

One fourth-grade teacher had her sixth-grade assistants come in a half-hour before school, to work with children to whom they were giving help. Because only two or three helpers were working at the same time, it was possible for the teacher to keep an eye on how things were going and to make suggestions.

Most of the tutoring was done during the same time that the rest of the class was studying the subject—as in a reading period or arithmetic class. The helper would work closely enough to the teacher for her to make suggestions.

An example of at-the-elbow help on the first day of tutoring occurred when neither the pupil nor the helper knew the meaning of a certain word. The teacher came to the rescue with "Jim, did you know all my fourth graders have a dictionary in their

desks?" Jim picked up this lead. "Say! A dictionary of your own! That's great. Let's look it up."

At-the-elbow aid, in the early stages, helps the helper to become confident in using his newly acquired teaching techniques. It gives him the same feeling of success that the teachers want him to inspire in his pupil. At the same time, it lets the teacher keep a quality control on his performance.

Beneficial Outcomes

In the course of our pilot studies, we have asked teachers and students to comment on their experiences. One teacher reported on Bob and Ted, two of her fourth graders:

"Bill was to help Bob choose and read a library book. After successfully finding a book on Monday, the boys returned to the room and began reading it. Bob became so interested that he did nothing but read his book all day. Bill returned on Tuesday morning to see how far Bob had progressed, and was surprised to find that he had covered four chapters. Bill took out some phonetic 'flashcards' and showed Bob a method of analyzing words. Bob was very enthusiastic about finishing the book and getting another. This was a complete change in Bob's attitude toward reading. Previously, he had had no interest in reading a library book."

"Ted has responded very well during the past 2 weeks. He finished his arithmetic assignment and is more alert to everything going on. The added personal attention motivates him to read, to do his arithmetic, and to want to get his work done."

Another teacher reported:

"The status of boys and girls in their own classroom has been increased by special attention from sixth graders. Fourth graders have learned that trained sixth graders can be of great assistance. The added drill has increased the learning of my low group, and has given them a better feeling about themselves. The limited enrichment program provided by sixth graders has motivated top pupils and middle pupils to do more and better work."

A majority of the older students were eager to be involved in this type of helping program. This was particularly true of low-achieving students, of lower socioeconomic status. Their relationship to adult authority figures (their teachers) was improved and their motivation to learn increased. A sixth-grade teacher reported:

"I was the at-the-elbow supervisor for physical education helping. Three sixth grade-fourth grade pairs, in basketball and tumbling, were working simultaneously. It was the second or third time for most of them. It was as perfect an example of this kind of fieldwork as could be hoped for. The helpers and the fourth graders had a sense of accomplishment as they practiced. With good preparation of the helpers, a large number of pairs might very well work with only one supervisor after the first period."

Another teacher, of an older group, reported:

"The children return from helping sessions with an increased will to do well in their own work. This has made more effective the time spent on the work in class. It has increased the self-respect and belief in their own ability of all of my defeated children, thereby contributing much to making them capable of learning."

The older children have given reports indicating that they have obtained deep personal satisfactions in this type of helping opportunity, and have gained insight into themselves and others. For example:

"They (kindergartners) also have troubles. You wouldn't think they had troubles. Everyone has problems. They don't like to be told what to do. They want to make up their own minds."

"Sometimes everyone thinks teachers are real mean and you realize now they just try to help you."

In one seminar, sixth graders were asked what they would say to a shy child who, daring to show aggression for the first time, said: "I'm a hippopotamus, and I will bite you." One boy answered: "I'm a tiger, and I am your friend"; and another, "I am a baby hippopotamus, and you can take care of me."

New Opportunities for Children

As we have continued to work with children, teachers, and counselors on utilizing the resources of older children in educational and related settings, we have been impressed and gratified by the enthusiasm with which both children and adults have reacted to this experience.

In a society in which motivation to learn is an increasingly critical issue, and in which service roles are the most rapidly expanding occupational areas, there is an urgent need to provide youngsters with opportunities to engage in relevant and meaningful service activities during their school years.

This places an obligation on those working with children to find new ways of providing them with opportunities to take initiative and responsibility, to test out newly developing skills, to learn about the gratifications of achievement and of helping others to achieve, to develop skills of relating more effectively to others, and to develop an appreciation of the value of understanding themselves and others.

¹ Fox, R. S.; Lippitt, R.; Lohman, J. I.: Teaching of social science material in the elementary school (final report on Cooperative Research Project E-011, U.S. Office of Education). Institute for Social Research, University of Michigan, Ann Arbor. 1964.

² _____: The innovation of classroom mental health practices. In: Innovation in education. (Matthew Miles, ed.) Bureau of Publications, Teachers College, Columbia University, New York. 1964.

UNMARRIED MOTHERS WHO KEPT THEIR BABIES

ELLERY F. REED

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THE seriously disadvantaged status of many unmarried mothers who keep their babies was evident in a study made recently in Cincinnati, Ohio, of 118 unmarried mothers who kept their babies.¹ In spite of these disadvantages, the investigators found that most of the mothers, if they had the decision to make again, would keep their babies.

The study was carried out by Social Welfare Research, Inc., YWCA, Cincinnati, through personal interviews by caseworkers and the study of social agency records. Because of the impossibility of selecting a "typical" sample, it was based on cases that could be found through social agencies and in which the mother was willing to cooperate. The agencies were: the Hamilton County Department of Welfare, three private maternity homes, and the Catholic Charities Archdiocese of Cincinnati. More than half the mothers had been residents of maternity homes. By design, no mother was included in the study who had more than two children: 90 percent had only one child. Two-thirds of the mothers were white.

Forty-seven (40 percent) of the mothers were receiving financial assistance through the Department of Public Welfare. Twenty-two (19 percent) were dependent on parents or relatives. The remaining 49 (41 percent), including 16 who had married, were financially "independent." Some of these, however, were living in conditions of real poverty and deprivation. They were not eligible for public assistance because the public assistance grants were based on 70 percent of a minimum budget. Those who were on public as-

sistance received little casework service because of the large caseloads.

The mothers ranged in age from 15.5 years to 47.5, but the large majority were 18 to 25 years of age. Twenty-nine were in the age group of 25 or over. Only 8 were under 18 years of age.

Only 32 of the 118 mothers had completed high school; 3 had had some college work. Fifty-three had completed only part of their high school education. Twenty-six had completed only the sixth, seventh, or eighth grades, and 4 had had even less education. Only 15 of the entire group had had any vocational education.

Mothers and Children

Thus, in general, these unmarried mothers on whom rested the heavy responsibility of a child were poorly prepared educationally to support themselves, to say nothing of their babies.

Less than 30 percent of the mothers were employed. Twenty-five of the 34 who were employed worked 40 hours a week or more. Restaurant and factory work were most common. Only 11 earned \$50 a week or more. The baby's grandmother in 15 cases was taking care of the baby while the mother worked. Other relatives gave this care in 4 cases, and other persons or agencies in 15 cases.

Most of those who were working before birth of the child did not return to the same job afterward.

Approximately half of the mothers were living in single-family-house neighborhoods where the general condition of the housing was rated as good



or fair. Of the half who were not in adequate housing, 23 lived in a house or apartment unit which had no bathroom. In 9 cases there was no indoor toilet in the building. In 35 cases there was no central heat.

The great majority of housing units did have hot as well as cold running water, but eight did not. In the majority of cases the laundry facilities were rated as good or fair.

Physical examinations were secure for the babies but not for the mother. The majority of the mothers (85 of the 118) reported that they had had the regular 6-week medical checkup for the baby; 104 of the babies had been immunized against diphtheria, pertussis, and tetanus; 86 against smallpox; and 46 had had other types of preventive health care. However, 26 of the 118 babies examined were rated by the examining physicians as needing some medical care.

Psychological tests of 115 of the children indicated a fairly normal distribution of IQ's. A majority (79 of the 115 examined) were included in the IQ group, 90 to 109. Twelve had IQ's of 110 to 119 and 4 had 120 or over. Five had IQ's of less than 80.

Twenty-two of the mothers were now

married; 8 to the child's father. Of the remainder, 23 said they dated frequently, 29 occasionally, and 44 not at all. Dating was more frequent among the white than among the Negro mothers. The interviewers found that some mothers who said they did not date at all understood the term to mean literally "going out with a man," and not to include entertaining a man at home. Some mothers who said they did not date were again pregnant.

In the majority of cases the dating was not with the alleged father. Few of the alleged fathers—whether middle or lower income or dependent, white or Negro—showed any consistent interest in either the mother or the baby. Only 5 contributed at all to the child's support. Of these, 9 contributed voluntarily and 16 under court order. In most cases the support was inadequate or irregular.

A majority of the 22 marriages were represented by the mother as happy at the time of the interview; and 17 of the 22 husbands were reported to show constant interest in the baby. Thirteen of the 22 men had full-time employment; the others had only part-time employment or none at all. Only six had finished high school.

Most of the mothers reported attending church only occasionally or not at all; 26 said they attended regularly, only 27 said they were participating at all in church recreational or social activities and only 6 of these said they were doing so regularly. However, 33 mothers reported that a clergyman had established a pastoral relationship with them, and 25 of these said they had found this helpful.

The majority of the mothers said they had kept up with at least some of their friends, but 24 had not maintained contacts with any of their former friends. Only half the mothers (59) said they had made new friends.

Some of the mothers laid their difficulty in keeping in touch with their friends to the fact that they had no one with whom to leave the baby. Lack of bus fare was also mentioned.

Only 24 mothers said they enjoyed reading. Four could not read at all and several found reading so difficult that it was not enjoyable for them. Forty-eight mothers kept their radios or televisions going 4 hours or more per day. Thirty-six mentioned other hobbies.

Why They Keep Their Babies

Problems of support seemed to have had little weight with most of the mothers as a consideration against keeping their babies. The idea or possibility of placing the baby for adoption had apparently never occurred or been presented to many of them. For the Negro mothers the opportunities for placing their babies for adoption were slight, and so there was less reason for this idea to receive consideration. Some mothers, including both Negroes and whites, seemed to have strong convictions that it would be wrong to give up the baby to anyone else. Many of the unmarried mothers of lower socioeconomic status apparently felt little social stigma or embarrassment about their unmarried status.

Emotion, rather than realistic considerations for the welfare of the babies and themselves, seemed largely to deter-

mine the choice to keep the baby in those cases in which there was a choice. The mothers made such remarks as: "Could I cast away my own flesh and blood?" "I'd grieve myself to death if I let my baby go." Some indicated that the baby would provide them with an interest in life—"something to live for." Some said they had hopes of marriage. Some hoped if the father saw the baby he would change his mind and marry them.

The great majority of the mothers (101 out of 118) said if they had the decision to make over again they would again keep the baby. This held for every group—white and Negro, middle and lower income and dependent groups. (The study found only one mother classified as belonging to the upper economic class who had kept her baby.)

Parental influence was mentioned by 21 mothers as a factor in causing them to keep their babies. Two mentioned the influence of a clergyman.

The findings of this study constitute a challenge to both public and private health and welfare agencies. Most of these mothers were in need not only of social services and adequate financial assistance but also of other community services, including those dealing with health and housing, education, recreation, and religion. Unless they receive such help, their future (and the future of their babies) is likely to hold continuing poverty, dependence, delinquency, and poor opportunity.

¹ Reed, Ellery F.; Latimer, Ruth: *Study of unmarried mothers who kept their babies*. Social Welfare Research, Inc., YWCA, Cincinnati, Ohio, 1963.

There is some danger in the current usage of the term "culture of poverty" because it suggests that something other than absence of money distinguishes the poor as a group from the rest of us. It is true that poverty is discouraging, debilitating, and cuts people off from the mainstream of American life. But there is a danger in suggesting that these qualities are intrinsic to the poor themselves rather than the end-product of remediable social ills. The danger lies in the ease with which this assumption moves toward the charge that the poor are poor by their own fault.

Elizabeth Wickenden, Technical Consultant on Public Social Policy, National Social Welfare Assembly, in "Notes on Poverty: Cause and Cure," a memorandum prepared for the assembly, 1964.

HERE AND THERE

Conference on Group Care

In an effort to determine under what conditions it may be feasible to establish a demonstration in group care for infants and young children in Metropolitan New York, under the Federal child welfare research and demonstration grants program, the Children's Bureau held a small 1-day conference in Washington, D.C., in late January.

Besides selected staff from the Children's Bureau, the conference participants included representatives from the New York City Department of Welfare, the Citizens' Committee for Children of New York, the Child Welfare League of America, the United Nations Bureau of Social Affairs, the New York School of Social Work, the New York Fund for Children, the Upstate Medical Center of the University of New York at Syracuse, the Children's Hospital of the District of Columbia, and others concerned with finding ways of providing care for young children whose parents are unable to provide it.

Among the facts and expressions of opinion brought out in the conference:

- Estimates indicate that 270,000 children in this country live in some kind of foster care; of these, 77,000 are living in institutions. There are 9,000 children less than 6 years of age in group care and almost 2,000 of them are less than 1 year old. In addition, 7 cities with populations of 100,000 or more report a "problem" of well babies remaining in hospitals because there is no place for them elsewhere.

- In New York City, there are 22,000 children away from their own homes in care of the Department of Welfare, with approximately 1,500 awaiting care. The incidence of family breakdown is swollen by the economic and housing problems of in-migrants from the South and from Puerto Rico; and the difficulty of finding foster parents is enhanced by the scarcity of space in normal living quarters. The problem of providing care for children is exacerbated by the absence of any comprehensive planning for child care in the city: lack of

sufficient funds or authority for providing care; confusion of responsibility between public and voluntary agencies; and failure over the years to test what is effective in the foster care field.

- In all parts of the country, many children are kept in "temporary" institutional care year after year, awaiting opportunities for a more permanent arrangement. While controversy rages between the proponents of foster family care and institutional care, insufficient good care of either type exists. Too often, comparisons are made between poor institutions and good foster homes, or between poor facilities of either type and good "own" or "natural" homes.

- While more recent studies of foster family care indicate that many children in such care do poorly, such findings may be compared to those of a previous decade in which institutions were found to be a sterile and depriving atmosphere for children. What all these studies have in common is that poor care, whether individual or group, leads to serious negative consequences for the child. What is needed to meet the differential needs of the many children in the care of child welfare agencies is improvement in all forms of child care as well as development of new forms.

- With more funds, innumerable innovations could be introduced and more and better families could be recruited. Homemaker services, casework, financial assistance as needed, a fair board rate, improved "working conditions" and "fringe benefits" could improve the quality and availability of good foster homes.

- Even with all these improvements there still would be a need for group care and a need to know which children need which form of care.

Descriptions were given of two research and demonstration projects in group care of infants and young children being supported by the Children's Bureau: the Children's Center of the Upstate Medical Center at Syracuse, N.Y., which provides day care and services to parents in a low-income area; and a program still in the planning

stage at the Yale University Child Study Center, which will attempt to compare the effect on children of group residential care, foster family care, and the provision of services to children in their own homes. Also described was a project dealing with the care of infants at the Children's Hospital of the District of Columbia, supported by the National Institute of Mental Health.

The conference arrived at the consensus that "it is time for New York City to set up a research and demonstration program for group care of children, including infants." There was further agreement that such a demonstration should be under the auspice of the New York City Department of Welfare, which has a wide variety of resources as well as primary responsibility for infants and children in need of child welfare services. It would be research oriented and would draw on what is known about the developmental needs of infants and young children on the one hand, and about group care on the other, in providing care for children who cannot be reared in their own homes, who need long-term care, and who are now either minimally served or actually damaged in the first months of years of life.

One of the unresolved questions was whether a group care program could be designed for very young children which would take into cognizance the child's need for continuity of care as he grows older.

Further discussions of methods of implementing the project are being held by a working committee of the conference participants.

—Charles P. Gershenson

Day Care

Pointing out that the Public Welfare Amendments of 1962 emphasized day care services as part of the broad range of public child welfare services, the Commissioner of Education and the Commissioner of Welfare, Department of Health, Education, and Welfare, recently issued a joint statement of agreement on the functions of day care as child welfare service and preschool education as part of an educational program.

Purpose of the statement was to provide guidelines for the Federal agencies charged with the development of programs for preschool children—especially the Welfare Administration.

which is concerned with the development through the Children's Bureau of day care as a part of child welfare services, and the Office of Education, concerned with the development of pre-school education as a part of a total education program. The Office of Economic Opportunity is interested in encouraging both types of programs through its community action grants. The essential function of day care as a child welfare service is described in agreement as giving "care and protection to children as a supplement to parental care." The statement points out that such care is for "children who must be outside their own homes for part or all of the day because their parents are working or seeking work or otherwise absent from the home or unable for other reasons to provide adequate parental supervision." This service, it asserts, may be given in another family's home, or in a day-care center "for children who can benefit from a group experience." To be adequate, the statement maintains, the service "must combine the services of health, education, and welfare—services fundamental to the growth and development of the child."

The statement points out that the purposes and the reasons for which a child and family need and use the service distinguish a day-care service from such educational programs as nursery schools and kindergartens. "The essential function and purpose of preschool education," it states, "is the training, education, and development of the child."

In Seattle, Wash., a group of licensed foster day-care mothers have formed an organization, the King County Chapter of Day Care, devoted to continuous improvement of their child-care responsibilities. The chapter resulted from the course for foster day-care mothers sponsored in King County by the Washington State Department of Public Assistance. Composed of some 30 members, it holds regular meetings, sponsors institutes, publishes newsletters, and provides the department with some volunteer clerical services to help in the efforts to upgrade and expand foster family care in the county.

The course out of which the organization grew was the first of a series of eight-session "lecture-discussions" initiated by the department's day-care specialist in 1963. Topics of the ses-

sions were: (1) new dimensions in foster care; (2) emotional, physical growth and development; (3) experimental theories in child development; (4) encouraging creativity in children; (5) safety in the home; (6) insurance information; (7) the legal aspects of day care; and (8) early recognition of emotional disturbance in children. Among the community resources which sent representatives to conduct the sessions were the Family Life Education Association, the Childbirth Education Association, the University of Washington, the local fire and public health departments, the American Red Cross chapter, the local office of the Internal Revenue Service, and an insurance company.

Participation in the educational course, now in its fourth series, is on a voluntary basis, the participants being referred by the department's caseworkers or by members of the King County Chapter of Day Care.

In addition to the educational course, the department holds weekly orientation sessions open to anyone interested in foster day care and required of all applicants for licenses.

As long as day care of children is regarded exclusively as a diagnostically selective therapeutic social service for children, rather than as a "developmental provision" to enhance child rearing, day-care services are not likely to expand to meet the needs of mothers and children in the socially and culturally deprived centers of our large urban areas, according to the report of a study of day-care programs in New York City recently made under the auspices of the Columbia University School of Social Work. ("Day Care as a Social Instrument: A Policy Paper," by Anna B. Mayer with the collaboration of Alfred J. Kahn.)

Granting that the expansion of the therapeutically oriented type of day-care service is needed as an important child welfare resource, the report emphasizes the further need for a more broadly inclusive preschool program with a comprehensive child development focus for 3- and 4-year-olds. It recommends an educationally based program of neighborhood "beginners' day schools" in which the disciplines of health, education, and welfare are synthesized "rather than merely coordinated." Such schools would be flexible

in the length of the child's day and would provide a year-round service. They would not require that the child have a "working mother" or any other means test for admission.

The authors anticipate some opposition to such a new "social utility" from those forces "dedicated to . . . the economic and social needs tests" and other limitations which, they maintain, restrict services to a small portion of those needing them.

The report estimates a need for space for 40,000 children in such a program in New York City. It points out that, at present, there are 5,000 children in publicly supported day-care centers; 11,000 in voluntary commercial or sectarian programs; and 1,500 in board of education preschool programs.

Homemaker Service

The development of a code of standards for homemaker services was the focus of a 3-day workshop held by the National Council for Homemaker Services in Princeton, N.J., March 10-12, with cooperative sponsorship from the Children's Bureau and the Bureau of Family Services, Welfare Administration, and the Public Health Service. The 60 participants included social workers, nurses, home economists, physicians, specialists in education and community organization, and representatives of governing boards of agencies providing homemaker services from all parts of the country. Many of them were members of the council's committee on standards and its six subcommittees which have for several months been studying existing agency policies and developing statements for consideration as parts of the code.

The discussion at the meeting centered on these tentative statements. Recommendations for revisions and additions were made and will be incorporated by the committee on standards in a preliminary code to be presented for further discussion at the 1965 forum of the National Conference on Social Welfare at a session on May 25 entitled "Homemaker Services—Circa 1965."

The committee on standards consists of representatives of 17 national health and welfare organizations and 3 consultants from the U.S. Department of Health, Education, and Welfare, in addition to the chairman, who is a board member of the National Council for

Homemaker Services. The subcommittees are composed of members of the committee, plus 40 additional people directly concerned with homemaker services.

The goal for the code is one that is comprehensive and flexible enough to be applied by the various types of agencies providing homemaker services, but will still assure a high quality of service. The six areas of responsibility selected for inclusion in the code are: (1) purpose and function; (2) organization and administration; (3) records; (4) training and continuing education; (5) staffing; (6) community relations.

Against Poverty

Some 200 home economists from various occupations and geographical areas met in Chicago for 5 days in mid-March to learn more about the problems and needs of low-income families and the agencies serving them, and to discuss ways of applying their special skills and services to the welfare of such families. Sponsored by the American Home Economics Association, the workshop was the first step in a plan to help home economists throughout the country play a greater role in improving conditions among the poor.

The participants came from five types of settings: college and university teaching and research; elementary and secondary education settings; health and welfare programs; cooperative extension services; and business firms. Each agreed to take responsibility for extending the message of the workshop to other home economists by helping to develop one area or State workshop of a similar nature.

In the meetings, the home economists were encouraged to develop long-term as well as short-term crash programs to help families break out of the poverty cycle. Their goal, as identified for the workshop in a message from Sargent Shriver, Director of the Office of Economic Opportunity, is to "bring unity, strength and hope to the impoverished family. . . ."

. . .

A recent study of the AFDC caseload in 10 Texas counties showed that more than 70 percent of the families receiving aid to families with dependent children had income other than their AFDC grants, a fact which the investigators maintain opens to question the "mythology" that families receiving public

assistance are unwilling to provide for themselves.

Supported in part by a grant from the Vocational Rehabilitation Administration, U.S. Department of Health, Education, and Welfare, the study was carried out by Morris Kagan of the University of Texas School of Social Work; Patricia P. Hakes of the Austin Community Guidance Center; and Maurine Currin of the Texas State Department of Public Welfare. They found that the presence or absence of supplementary income was not significantly related to the length of time the family had received assistance.

The study indicated that most of the AFDC recipients who contribute to their own support are still unable to meet their needs adequately: 77 percent of those with supplementary income still had unmet financial need after receiving the AFDC grant, as had 83 percent of those without supplementary income. The investigators regard this as an indication that the rehabilitative purpose of AFDC is not being accomplished.

The investigators also found a flaw in the idea that mothers in families in which the AFDC payee is a male are more likely to contribute to the family's support because of having a convenient baby sitter in the home: only 25 percent of the mothers in the families with male payees are working, as against 55 percent of the mothers in the families with female payees.

Nurse-Midwifery

Although nurse-midwives are employed in a variety of positions, only 34 nurse-midwives in the United States are *practicing nurse-midwifery*, according to the definition of this occupation arrived at in a study recently completed by the Children's Bureau. As part of this study, the investigator compiled a list of 630 names of nurse-midwives prepared or working in the United States, 95 of them known to be working outside the country now. Of the 501 who were in this country and not practicing nurse-midwifery, the majority were in positions in which their knowledge of midwifery was used to some degree.

The study, which was made on the recommendation of the Association of State & Territorial Health Officers, focused on both the extent and nature of nurse-midwifery practice in the United States. The extent of practice was de-

termined in cooperation with the American College of Nurse-Midwifery, correspondence with schools of midwifery, and through announcements in nursing journals. The nature of the practice was determined by interview with 30 of the 34 practicing nurse-midwives and with 32 physicians and administrative nurses associated with these nurse-midwives in their practice.

Statements related to physicians' and nurse-midwives' responsibilities in desirable practice were developed, and each respondent was asked to reply to each statement in two ways: "Does the statement apply to the situation in which you work?" and "Do you think it is a sound statement which should apply wherever nurse-midwives practice?"

Among the findings:

- There was full agreement among the respondents that nurse-midwife practice should be administratively affiliated with medical practice.

- There was substantial agreement among all types of respondents that the physicians would be expected to (1) screen all patients for those suitable for assignment to nurse-midwives for care; (2) maintain or reassign responsibility for the management of mothers with complications; (3) recheck patients assigned to nurse-midwives at specified intervals, usually toward term (there was some disagreement here); some of the respondents believing that the nurse-midwives were capable of determining when reexamination by physician was indicated; and (4) supervise the *midwifery* functions (as contrasted to the nursing functions) of nurse-midwives.

- There was essential agreement that the practicing nurse-midwife is capable of (1) providing complete antepartum care to patients assigned to her, as long as the pregnancies are normal; (2) managing normal labor; (3) conducting normal delivery; (4) providing immediate care of the newborn; and (5) evaluating and supervising the progress of normal post-partum mothers.

A substudy focused on the attitudes of the physicians toward nurse-midwifery. This was done to test the hypothesis that physicians who had had experience with nurse-midwives—as had all the physicians in the study—would have a highly favorable attitude toward the practice. The scores obtained from a series of attitude statements responded to by these physicians seem to

the opinion of the investigator, to prove the hypothesis.

A full report of the study will be published by the Children's Bureau in the near future.

Concerned over (1) the limited types of experience available in the past to nurses who have desired to study midwifery in the United States, and (2) the scarcity of educational opportunities for professional midwives who need sound orientation in the broad aspects of maternal and child health, including nursing, the Division of International Cooperation of the Children's Bureau, in cooperation with AID (Agency for International Development), is developing training opportunities for these nonmedical health personnel engaged in maternal and child health services.

Programs will be developed in cooperation with educational and service agencies for foreign nurses and midwives, to help them improve their administrative and teaching skills; to aid them in cooperating with their colleagues in the development of a comprehensive maternity service within their own countries; and to stimulate them to assume leadership for the education of future nurses and midwives.

Child Welfare

Children of women prisoners are the object of concern in a two-part study project being undertaken in California under the sponsorship of the State Departments of Social Welfare and of Corrections, with the assistance of the Jewish Committee for Personal Service, Los Angeles, and with the use of Federal child welfare services funds. The project is focused on the children and families of women in the State's only institution for women, the largest State penal institution for women in the United States. In August 1962, when the first phase, a preliminary study, was getting under way, the institution held 29 women, 520 of whom were the mothers of minor children—1,200 children in all.

This first study phase was completed last year and has been reported on in a monograph by Serapio R. Zalba in collaboration with Lois M. Tandy and Cynthia E. Neshit. ("Women Prisoners and Their Families.") Focused on the relationship of the institution with community social agencies, its purpose was to develop understanding of the

problems involved in designing programs to meet the social welfare needs of the families and children. Through analysis of official records and the use of questionnaires and personal interviews, data were gathered on the women, their children, and the agencies which had provided or were providing social welfare services to them.

The investigators found "few indications of family-oriented planning, especially for the future of the children," and little opportunity for person-to-person contact among staff members of different agencies which had worked with them. The children tended to be "unstable . . . exhibiting diffuse anxiety, apprehension, uncertainty," and, in general, had been moved around considerably, sometimes for years, experiencing previous separations from siblings as well as from parents. In many cases, when social agencies had attempted to arrange long-term foster care, the mothers had been bypassed in the formulation of the decision, and in the end had sabotaged plans.

The investigators recommended co-ordinated family-oriented planning between social welfare agencies and the institution to provide these families with assistance in the placement of children and in the development of realistic short-term and long-term family goals and plans; to provide the mother with assistance in working out her feelings toward her children in preparation for making long-term arrangements for care; and to arrange for referral of family members to appropriate social welfare resources.

A few copies of the monograph are available without charge from the California State Department of Social Welfare, 2415 First Avenue, Sacramento.

The second phase of the project—a demonstration to implement and evaluate procedures for carrying out these recommendations—is now under way.

A plan to make emergency protective services available to children on a 24-hour, 7-day-week basis throughout the State of Illinois was initiated early this year by the Illinois Department of Children and Family Services. For this purpose, the department established a telephone answering service in the State capital, Springfield, to accept and relay calls from and to any community in the State. Through this communication system, caseworkers in the de-

partment's eight regional offices who have been assigned to on-call duty after hours are informed of situations requiring their attention only a few minutes after a report of child neglect, abuse, or exploitation has been received.

The plan extends to nights and week ends, the protective service already being provided through the department's regional and branch offices during the day on weekdays; the provision of consultation to local officials and others concerned about situations involving the abandonment, abuse, neglect, or exploitation of children, and the emergency placement of children when immediate protective action is deemed necessary.

Mental Retardation

Early this year, the American Academy of Pediatrics issued a statement recommending that, before they are discharged from the hospital, all newborn infants be tested for phenylketonuria (PKU), an inherited metabolic disorder which, unless detected and treated, results in mental retardation. Through its Committee on Fetus and Newborn, the academy also urged that a second test for PKU be performed at 4 or 6 weeks of age to detect infants with borderline or low levels of phenylalanine—the amino acid which babies with PKU are unable to metabolize. The committee further recommended that all newborns be tested for two other inherited metabolic disorders, galactosemia and fructosemia, which, interfering with the body's ability to utilize certain types of sugar, may lead to retardation or death.

Concern about the difficulties parents of mentally retarded children experience in getting dental care for their children prompted the Children's Bureau and the University of Tennessee College of Dentistry to hold a 2-day meeting of experts in child dentistry on March 8-9, 1965, at the college in Memphis, as a first step in developing guidelines in care of the mentally retarded child for the practicing dentist.

About 25 dentists from private practice and clinic programs attended, all with experience and special skill in the dental care of handicapped children.

Preliminary guidelines based on the points presented in the March meeting are being prepared as a basis for discussion at a regional working conference to

be held sometime within the next few months. At this conference, also to be held in Memphis, representatives from public health departments, dental schools, and private dental practice from six States in the southeastern region of the United States (DHEW Region IV) will come together to determine the final content of the guidelines. These will be presented in a publication to be issued by the Children's Bureau shortly thereafter in an effort to motivate the dental profession to provide more services of high quality for mentally retarded children.

ICY and Youth

A Youth Activities Committee was set up in the Federal Government in mid-March as one of the 28 committees working on observance of International Cooperation Year, designated by the United Nations General Assembly as 1965 to coincide with the U.N.'s 20th

anniversary, and proclaimed by the President on October 2, 1964. Each of these committees consists of a chairman from the Government department most directly involved in the subject of the committee and members representing departments or agencies having an interest in the committee's area of concern.

The chairman of the Youth Activities Committee (YAC) is James M. Quigley, Assistant Secretary of the Department of Health, Education, and Welfare, who represents the Department on the Cabinet Committee on International Cooperation Year. Helen K. Mackintosh, Chief of the Elementary School Organization Section in the Office of Education is co-chairman.

This committee, defining "youth activities" broadly, and working through the structure of the Interdepartmental Committee on Children and Youth, and its Executive Secretary, Mary E. Blake,

will (1) make an inventory of international cooperative youth activities now carried on in each agency represented by its membership; (2) develop recommendations for new areas of cooperation or for expanding existing international activities; (3) look for ways to increase public understanding of the scope and effectiveness of U.S. activities in the international field; and (4) prepare a working paper for a White House Conference to be held November 29-December 1, 1965.

The YAC will work with a counterpart nongovernmental Citizens' Committee, which has been established by the United Nations Association. The chairman of the YAC Citizens' Committee is Rev. James H. Robinson.

Among the 27 other Federal committees concerned with International Cooperation Year are committees on education and training, welfare, and health

Guides and Reports

STRATEGY OF CHANGE: Summary of Joint Conference on Children and Youth, April 5-8, 1964. Washington, D.C. National Committee for Children and Youth, 1145 19th Street NW, Washington, D.C. 20036. 1964. 48 pp. Mimeographed. \$1.25.

Contains the reports of the constituent groups—the Interdepartmental Committee on Children and Youth, the National Council of State Committees for Children and Youth, and the Council of National Organizations for Children and Youth—the major addresses, and a Conference Summary. The theme: "Translating New Concepts Into Services for Children and Youth."

ENTERIC INFECTIONS: Report of a WHO Expert Committee. World Health Organization Technical Report Series No. 288. Geneva, Switzerland. Columbia University Press, International Documents Service, 2960 Broadway, New York, 10027. 1964. 36 pp. \$1.

This report of a 1963 meeting on "the most important cause of sickness and

death among children" in many of the developing countries discusses the complex interrelation of biological, social, and economic factors involved in the persistence of enteric diseases.

OPENING NEW DOORS TO THE CEREBRAL PALSY THROUGH DAY CARE AND DEVELOPMENT CENTERS. Elsie D. Helsel, Sherwood A. Messner, and L. Leon Reid. United Cerebral Palsy Associations, 321 West 44th Street, New York, 10036. 1964. 50 pp. Single copies available free on request from UCPA.

A guide for the operation of day-care centers and development classes for severely and multiply handicapped children, teenagers, and adults.

PUBLIC WELFARE: POVERTY—PREVENTION OR PERPETUATION; A Study of the State Department of Public Assistance of the State of Washington. Greenleigh Associates, Inc., 355 Lexington Avenue, New York, 10017. 1964. 277 pp. \$5. This comprehensive study of a State's

public welfare program examines its various programs, their structure, and methods of operation against the current needs of families and children within the State and the availability of other resources for meeting them.

FEDERAL AGENCIES FINANCING RESEARCH: The 1964-65 Guide to Government Grants and Contracts. Social Legislation Information Service, 1316 Connecticut Avenue NW, Washington, D.C., 20036. Revised edition. Document 18. 1964-65. 72 pp. \$2.

Describes 48 research grant and contract programs administered by agencies of the Federal Government, 9 of them authorized under public laws passed by the 88th Congress in 1964 late in 1963.

REPORT OF THE 1964 NATIONAL CONFERENCE ON HOMEMAKER SERVICES. April 29-May 1, 1964. Washington, D.C. Virginia R. Dasher. National Council for Homemaker Services, 1790 Broadway, New York, 10019. 1965. 76 pp. \$1.

Reports on the needs and status of homemaker services today, as revealed in the more than 80 papers presented at the conference.

BOOK NOTES

THE DEVELOPMENT OF MOTIVES AND VALUES IN THE CHILD. Leonard Berkowitz. Basic Books, New York. 1964. 114 pp. \$2.95.

Pointing out that his book is concerned with "socialization—the process by which children learn to become adult members of their society," the author, professor of psychology at the University of Wisconsin, focuses on two specific aspects of child development—achievement motivation and moral development—and summarizes recent findings of research regarding cultural, religious, social-class, and familial influences on each. He also gives attention to the role of the child's identification with his parents and to the question of the operation of motives and values in governing behavior.

The studies he has evaluated "add up," he says, "to one important point"—namely, that parents who want their children to be "reasonably successful" must take an active part in developing in them appropriate values and motives. Children's wishes cannot be indulged in the hope that they will then automatically develop the desired motives and values," which must be, on the contrary, "deliberately inculcated." If everyone could formulate his own moral standards without regard to the needs of others, concludes Professor Berkowitz, "we would have . . . anarchy."

DEVELOPMENTAL DYSLEXIA. Macdonald Critchley, M.D. Charles C. Thomas, Springfield, Ill. 1964. 104 pp. \$5.50.

Dr. Critchley, senior neurologist, King's College Hospital, London, and senior physician, National Hospital, London, has written a detailed study of a serious impairment of the reading faculty.

Both children and adults are subject to this condition, the medical term for which is developmental dyslexia. The popular, and more revealing, name is congenital wordblindness.

Although Dr. Critchley lists some 165

studies of dyslexia in the bibliography, specialists are by no means in agreement as to its etiology.

But, writes Dr. Critchley, "The outlook is anything but hopeless. With appropriate tuition, dyslexics can make considerable progress and they may attain sufficient ability to read for all practical purposes."

The need for better understanding of this impairment is stressed in this book in a quotation from the writings of Dr. James Hinshelwood, an early student of dyslexia, who wrote in 1902:

"It is a matter of the highest importance to recognize the cause and the true nature of this difficulty [when] experienced by . . . children; otherwise they may be harshly treated as imbeciles or incorrigibles, and either neglected or punished for a defect for which they are in no wise responsible."

SCHOOL READINESS: Behavior Tests Used at the Gesell Institute. Frances L. Ilg and Louise Bates Ames. Harper & Row, New York. 1965. 336 pp. \$7.95.

The basic educational viewpoint of the Gesell Institute of Child Development, as described in this book, is that children should be entered in school—and therefore grouped and promoted—on the basis of their developmental or behavioral age, not on the basis of their chronological age or IQ. The authors, Dr. Ilg and Dr. Ames, are, respectively, the director and the research director of the institute, which was founded in 1930 in honor of the late Dr. Arnold Gesell.

They describe a study (initiated in 1957 with the support of the Fund for the Advancement of Education) in which they held interviews with 100 children, age 5 to 10, in 2 school districts in the Connecticut community of North Haven.

The basic tool used in these interviews was a specialized, seven-part "developmental examination," designed at the institute, through which the child is enabled "to reveal himself as a total

individual, telling us about his level and method of growing and his state of readiness for the different stages of the educative process." They maintain that the child's behavior level, as determined through such an examination, offers "the correct clue to good grade placement."

Samples of all the "developmental examination" test forms are printed in an appendix, together with instructions on how to give the tests, evaluate them, and make use of the results. "Test Materials and Recording Sheets to Accompany SCHOOL READINESS" may be purchased separately for \$1 from Harper & Row, 49 East 33d Street, New York City, 10016.

CARE OF CHILDREN IN DAY CENTERS. Public Health Papers No. 24. World Health Organization, Geneva. Available through Columbia University Press, International Documents Service, New York, 10027. 1964. 189 pp. (Paperback.) \$2.25.

The nine papers in this volume describe the administrative, health, and psychological aspects of day-care centers and other child care facilities in various countries, as well as the effects these services have on the child and his family. The emphasis is on the physical, social, intellectual, and emotional needs of children at various stages of development and the relation of these needs to the types of facilities provided, their location, and the daily program and activities.

Contributors include specialists in pediatrics, mental health, child development, and public health administration from Sweden, Germany, France, the United States, and Poland; and the International Labour Office. The paper by ILO presents trends in the employment of women—especially those with children—in various regions of the world, and the various types of facilities needed by working mothers.

DR. MONTESSORI'S OWN HAND-BOOK. Maria Montessori. Robert Bentley, Inc., Cambridge, Mass. 1964. 121 pp. \$5.

This is one of a growing number of republications of the works of Maria Montessori, originator of the Montessori method of preschool education. The book is of interest because of the many proposals for use of Montessori methods in preschool education programs today.

IN THE JOURNALS

Day Care

In the March 1965 issue of *Child Welfare*, a "Special Issue on Day Care," Milton Willner, associate director of a family day-care project in New York City, maintains that the profession of child welfare has confused maternal deprivation with separation, and, contrary to the evidence, according to his view, has equated multiple mothering with deprivation. ("Day Care: A Re-assessment.")

Examining the "basic question" of why day care is not more readily available to the children of working mothers in the United States today, Mr. Willner holds that this lack is the result of the "traditional reluctance" of the social work profession to separate mother and child, and the profession's failure to recognize the need to *plan* for the care of children of working mothers. Day care, he says, is not a substitute for any other service, but has unique values of its own in (1) providing the child with a variety of everyday experience that forms a basis for wider learning and expression; and (2) fostering a child's capacity for later learning. Any and all young children should be accepted into day-care programs, he concludes, because this would provide both education for the children and constructive, refreshing relief for the mother during part of the day.

Other articles in the issue describe a research-oriented day-care center in Syracuse, N.Y., for children from 6 months to 3 years of age, aimed at fostering their subsequent educability; a project to provide mental health consultation to teachers in three day-care centers in New York City; and a day-care center in Cincinnati, Ohio, "that blends education and social work" to help low-income families.

The Case for Counsel

In a discussion, in the January 1965 issue of the quarterly *Crime and Delinquency*, of whether the offender in a juvenile proceeding has a right to counsel, Eugene E. Siler, Jr., concludes

that "the most important right and the one that should be absolute is the right to assistance of counsel, through whose efforts any abuses of the court can be properly handled. . . . The child has a right to counsel, court-appointed when necessary; unless he has counsel to advise him properly, he does not have a true hearing." ("The Need for Defense Counsel in the Juvenile Court.")

The author does not base his conclusion on constitutional grounds, explaining that, since "juvenile proceedings are not criminal in nature but are an adjudication upon the status of the child and are a type of guardianship imposed by the state *in parens patriae* [the State as legal guardian], constitutional safeguards guaranteed to one accused of crime are not applicable to juvenile offenders." Rather, he bases his conclusion on application of "due process of law and fundamental fairness, while still retaining for the juvenile proceeding the whole theory of *parens patriae*."

He maintains that most lawyers who appear in juvenile courts do not fully understand the proceedings, partly because of the paucity of law school courses on such proceedings.

Transfusion in Utero

A new technique of transfusion delivered *in utero* to save fetuses with hemolytic disease (*erythroblastosis fetalis*), developed and first practiced in January 1964 by Dr. A. William Liley, of the National Women's Hospital, Auckland, New Zealand, has salvaged, to date, "about two out of three . . . formerly hopeless pregnancies," and "In the U.S., . . . could . . . save as many as 3,000 babies a year," according to an article in the January 1, 1965, issue of *Medical World News*. ("Saving Life Before Birth.") Since his first such operation, Dr. Liley has repeated the process over 40 times and other practitioners have performed some 60 similar operations on 4 continents, the article reports.

Erythroblastosis fetalis, the article points out, usually afflicts the offspring of Rh-negative women who, married

to Rh-positive men, have become sensitized to the Rh-positive blood of previous fetuses. In the technique described, about 200 milliliters of Rh-negative blood are injected through the mother's abdomen directly into the fetal peritoneum to provide enough added vitality to tide the baby over 2 or 3 critical weeks to safe delivery.

Dr. Liley described the technique at a meeting devoted exclusively to intrauterine surgery, held at Stowe, Vt., late in 1964 under the auspices of the National Institute of Child Health and Human Development and the University of Vermont. He is at the College of Physicians and Surgeons, Columbia University, on a fellowship from the National Institutes of Health, working on problems of placental physiology.

AFDC Groups

The practice of holding regular meetings of small groups of 6 to 10 recipient of aid to families with dependent children, to help them build constructively on their own inner strengths and to emerge from their "appalling" social isolation, is described by Louise C. Youngman, district supervisor, Department of Public Welfare, Baltimore, in the January 1965 issue of *Public Welfare*. ("Social Group Work in the AFDC Program.")

The article reports that in weekly hour-long group discussions, with trained social group worker in charge, mothers, and some fathers, have discovered that they are not alone with their problems of coping with inadequate income, unemployment, broken family relationships, community hostility, and the difficulties of maintaining satisfactory homes for their children. Group members are selected on the basis of common problems, such as mother who have been unsuccessfully seeking employment; mothers of children adjudged to be delinquents; or mother with physically incapacitated husbands.

In a detailed summary of one group's proceedings, the author quotes a mother as saying that the group helped her "to say things and ask questions" which she would have been afraid to bring up outside the group; and another as saying that it gave her "the first chance she'd ever had to talk about 'deep things.'"

Maintaining that the social group work method "offers AFDC parents . . . an opportunity to achieve a sense of

self-worth and belonging," the author cauds for more trained group workers in the AFDC program.

be Hospitalized Child

Noting that in some retrospective histories of children who have been hospitalized, "lasting neurotic patterns" have been traced back to the time of their hospitalization, Dr. Edward A. Mason, in the February 25, 1965, issue of *The New England Journal of Medicine*, calls attention to six ways of preventing or alleviating the traumatic effects of hospitalization on children. The Hospitalized Child—His Emotional Needs."

1. Avoidance of hospitalization. The author notes that home-treatment services maintain children's normal environment; that more thought is now being given before prescribing elective operations; and that fewer children are being hospitalized for routine evaluations.

2. Preparation. The author holds that an honest parental account of anticipated events can reduce the "strangeness" of hospitalization for the child.

3. Physical arrangements. Dr. Mason notes that many hospitals now

make their wards more homelike, with gay decorations, the provision of toys, play areas, and a central dining table for ambulatory children.

4. Liberalized visiting by parents. According to Dr. Mason, older patterns of limiting parents' visiting have given way, in many hospitals, to "a variety of patterns that allow flexibility."

5. Mother staying with child. Recognizing that separation from the mother is the chief traumatic factor for many hospitalized children, the author stresses the "therapeutic uses" of admitting mother and child together, the mother remaining through all treatments, tests, and examinations.

6. Staff relations. The author emphasizes the importance of an honest and comforting approach to the child.

Development of Conscience

Using four brief stories (a "Fight Story," a "Cup Story," a "Lost Story," and a "Scout Story"), Martin L. Nass of Brooklyn College recently investigated the development of conscience in deaf and hearing children, as reflected in the moral judgments made by them of the stories' contents. Mr. Nass, who carried on his research with the help of a fellowship from the National In-

stitute of Mental Health, has reported on his investigation in the December 1964 issue of the quarterly *Child Development*. ("Development of Conscience: A Comparison of the Moral Judgments of Deaf and Hearing Children.")

Thirty children, six at each age level from 8 to 12, all congenitally deaf and of average or slightly superior intelligence, were told the four stories. Questions were then asked: How do you think Louis felt about it? Should both boys be punished? Should one be punished more? The answers given were compared with those given to the same materials by 30 hearing children in a previous test conducted by Mr. Nass and a collaborator.

Mr. Nass concluded from his data that the conscience of deaf children matures slightly earlier than, or at about the same age as, children with normal hearing in "response to situations involving independence from adults and peer reciprocity;" that hearing children under 12 indicate significantly greater maturity in situations involving recognition of the distinction between motivation and the results of an action; but that by the age of 12, there are no measurable differences in conscience development.

READERS' EXCHANGE

TRINGER: An ethical question

The January-February 1965 issue of *HILDREN* contained a two-part article entitled "Homemaker Service in Neglect and Abuse," (Part I—Strengthening Family Life," by Louise Foresman; and Part II—"A Tool for Case Evaluation," by Elizabeth A. Tringer.)

Miss Stringer writes: "These acts range from battering a child in impulsive rage to deliberate intent to murder. In such situations, the use of homemaker service to assist a social caseworker in the evaluation of family strengths and weaknesses, and to provide facts based on direct observation, can be invaluable in helping a responsi-

ble agency to take appropriate action for the protection of the child."

May I ask, "What is the 'appropriate' action to be taken by the agency?" If it is court action for custody of the child, the information via the homemaker would be hearsay, unless the homemaker agrees to testify directly. If that is the case, it poses an ethical question for an agency to place a homemaker to secure evidence.

In commenting on a case of a 9-month-old boy who was made a hopeless cripple by his father's rage, Miss Stringer states: "Even when his father acknowledged the acts that resulted in Paul's becoming a hopeless cripple, the legal, medical, and social professions

were reluctant to heed this family's unspoken appeal for Paul's protection."

In response to this statement, I would say our society has failed miserably to construe such action as an appeal for help. Let us rather think of the basic constitutional right of a child to grow up. I think we should refresh ourselves by rereading the Children's Charter (1930) and act with those goals in mind.

Finally, I see homemaker service as a tool for rehabilitation which should be used *after* a careful evaluation by those who claim competence to make judgments as to its use in a particular situation. I think Mrs. Foresman, in Part I, illustrates this very well.

*Elvira G. Ager
Project Administrator, Eau Claire
County (Wis.) Youth Study*

Author's reply

The use of homemaker service in the diagnostic assessment of parental func-

tioning is by no means a new concept, but it is only recently that we have clearly stated this to be one of its primary uses. However, in no instance is a homemaker assigned without the family's full knowledge of the purpose of the service, complete acceptance of it, and stated willingness to participate. Fortunately, as Mrs. Foresman has indicated, in many instances the placement of a homemaker can improve family functioning through example and direct teaching. Or, the support and encouragement of a homemaker may enable the caseworker to help an exhausted, yet guilt-ridden, mother come to a decision to institutionalize a severely retarded child, thus freeing her to devote her energies more appropriately to the rest of her family.

Occasionally the combined services of the homemaker and one or more professional persons are insufficient to redirect well-established patterns which are serving to meet the pathological needs of the parents. When all other methods have been tried and have failed, intervention becomes the only means of protecting the child, as in the case of "Paul."

Some professional soul searching has been necessary to feel comfortable with this concept, not only in regard to parental rights and civil liberties, but also in requiring homemakers to observe record, and to testify. There are several excellent articles relative to this subject; among them the three papers compiled in the Child Welfare League of America's publication, "The Neglected Battered-Child Syndrome; Role Reversal in Parents." The knowledge that 22 States now have laws making it mandatory for doctors and hospitals to report cases of suspected child beating lends heartening support to our conviction that the life of a child must be the primary focus of our concern and action.

Elizabeth A. Stringer

Associate Director, Foster Care Services, Children's Aid Society, New York

HERZOG AND BERNSTEIN: A disappointing omission

The article "Why So Few Negro Adoptions?" by Elizabeth Herzog and Rose Bernstein, in the January-February 1965 issue of *CHILDREN*, makes several important comments on the

problems of placing Negro children for adoption. It is well that the presumption that Negroes are not "doing their share" of adopting is exposed as erroneous. The authors suggest that Negroes above the poverty margin of \$3,000 are apparently adopting children at a higher rate than whites.

A disappointing omission in this article was the complete ignoring of adoption agency efforts, either already under way or planned, to place nonwhite children in white families. To be sure, no significant number of Negro or part-Negro children have been placed in white families. However, several agencies have undertaken efforts to recruit white families to adopt minority-race children, with gradually increasing success.

For example, a 2-year recruitment project in Minnesota, financed from Federal child welfare services funds, called PAMY (Parents to Adopt Minority Youngsters), shifted its focus, after the first year's operation, from recruiting adoptive homes from among the minority races to recruiting in the community in general in behalf of minority-race children. Several white families have adopted part-Negro children. Agency staff members and board members have increasingly accepted and encouraged the appropriateness of such placements. Agencies in other States are turning their efforts in this direction.

The authors of "Why So Few Negro Adoptions?" point to the need for agencies to modify their policies and practices. Such modification should include the possibility of interracial placement.

Why should we presume that a child who is "part-Negro" should be placed only in a Negro family? After all, the child is most likely also "part-white."

With the increasing emphasis today on human relations, nondiscrimination, and racial integration, the climate is progressively improving for interracial adoption.

Charles B. Olds

Executive Director, Children's Home Society of Minnesota, St. Paul

A neglected potential

The earnest recommendations of Elizabeth Herzog and Rose Bernstein are pathetic in view of something like 16 times as many potentially qualified white families to take these kids as

there are potentially qualified nonwhite families. (This ratio is based on Herzog's and Bernstein's age under and over \$3,000 qualification criteria.)

Are Miss Herzog and Mrs. Bernstein unaware of this potential?

*Robert R. St. John
St. Paul, Minn.*

"Infuriating"

I found the Herzog and Bernstein article infuriating.

All the facts are carefully documented and clearly presented. Then, the obvious conclusion is completely ignored: white adoptive homes for Negro children.

*Rex Ragan
Foster Home Recruitment Director
Los Angeles County (Calif.)*

FOR PARENTS

CARING FOR YOUR DISABLED CHILD. Benjamin Spock and Mary O. Lerrigo. The Macmillan Co., New York. 1965. 373 pp. \$4.95.

HOW TO SURVIVE PARENTHOOD. Eda J. LeShan. Random House, New York. 1965. 242 pp. \$4.95.

HOW TO GUIDE YOUR SCHOOL-AGED CHILD. Leland E. Glover. Foreword by C. C. Trillingham. The Macmillan Co., New York. 1965. 285 pp. cents.

NOBODY SAID IT'S EASY. A practical guide to feelings and relationships for young people and their parents. Sally Liberman Smith. The Macmillan Co., New York, 1965. 223 pp. \$4.95.

YOUR ALLERGIC CHILD. Easy-to-understand guide for parents. Herman Hirshfeld. Arco Publishing Co., 219 Park Avenue South, New York 10003. 1965. 142 pp. \$1.45 paperback; \$3.25 clothbound.

WHAT TO TELL YOUR CHILDREN ABOUT SEX. Prepared by the Child Study Association of America. Foreword by Milton I. Levine, M.D. Duell, Sloan & Pearce, New York. Also available from the Association, 9 East 89th Street, New York, 10028. Revised 1964. 117 pp. \$2.95.

SOME U.S. GOVERNMENT PUBLICATIONS FOR PROFESSIONAL WORKERS

Publications for which prices are quoted are for sale by the Superintendent of Documents, U.S. Government Printing Office, Washington, D.C., 20402. Orders should be accompanied by payment. Twenty-five percent discount on quantities of 100 or more.

DAY CARE SERVICES: Why? What? Where? When? How? Department of Health, Education, and Welfare, Welfare Administration, Children's Bureau, CB Publication No. 420, 1964, 41 pp., 25 cents.

Addressed to parents, civic groups, and others interested in strengthening community day-care services for children, this illustrated pamphlet shows: why day-care services for children are needed; what types of services should be available to meet the individualized needs of parents and children; the kinds of staff they need; what kinds of supplementary services are required; and how the appropriate services can be developed and coordinated.

WHAT IS GOOD DAY CARE? Department of Health, Education, and Welfare, Welfare Administration, Children's Bureau, CB Folder No. 53, 1964, 11 pp., 15 cents.

Directed to parent groups and community leaders and agencies, this pamphlet describes the ingredients of

good day care services for children, explains the reasons some children need such services, and offers guidelines for getting a day care program under way.

YOUR CHILD FROM 1 TO 3. Department of Health, Education, and Welfare, Welfare Administration, Children's Bureau, CB Publication No. 113, 1964, 21 pp., 20 cents.

The second in a series of pictorial guides designed for quick and easy reading by parents of young children, this pamphlet highlights the points on child care that parents need to know and consider.

YOUR PRESCHOOL CHILD'S EYES. Department of Health, Education, and Welfare, Welfare Administration, Children's Bureau, CB Folder No. 54, 1964, 15 pp., 15 cents.

Written for parents, this pamphlet recommends inclusion of a professional eye examination in the preschool check-up of every child by age 3, even though he has no obvious eye abnormality or

visual problem. It also describes the symptoms of eye trouble in both preschool and older children which call for immediate examination when discovered by the parents.

THE CLINICAL TEAM LOOKS AT PHENYLKETONURIA. Department of Health, Education, and Welfare, Welfare Administration, Children's Bureau, Revised 1964, 56 pp., 40 cents.

All the papers in this revision of a 1961 publication have been rewritten by the original authors, six members of a multidisciplinary clinical team to present their extended observations on phenylketonuria and the problems encountered in providing services to the affected child and his family. The authors include a biochemist, a pediatrician, a medical social worker, a public health nurse, a psychologist, and a nutritionist.

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AN INTERDISCIPLINARY JOURNAL FOR THE PROFESSIONS SERVING CHILDREN

Adolescence and Its Problems
Refocusing Psychiatric Services
Expanding Child Welfare Programs
National Day Care Conference





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IN ADOLESCENT in communion with a book. Even such quiet moments, adolescents live in a world that typically more tumultuous, more subject to fluctuating moods, and in general more "difficult" than the

world of the child, which they are leaving, or the world of the adult, which they have not yet entered. The articles beginning on page 131 and page 136 throw revealing light on the adolescent's world.

On the Johns Hopkins faculty since 1953, as professor since 1961, Dr. Leon Eisenberg is a pediatrician and psychiatrist. President of the Maryland Psychiatric Society (1959-60), he served as consultant to the Baltimore City Hospital from 1958 to 1964. Editor of the *American Journal of Orthopsychiatry*, he is on the editorial boards of the *Journal of Child Psychology and Psychiatry* and the *Journal of Psychiatric Research*. He is a member of the U.S. National Committee on Vital and Health Statistics, Subcommittee on Classification of Mental Illness.



Dr. Ghislaine D. Godenne, a native of Brussels, Belgium, graduated in 1946 from the *Ecole Catholique de Service Social* with the degree of *assistante sociale* (social worker). She received her medical degree from the University of Louvain, Belgium. Prior to her appointment to her present post, she has been chief resident in pediatrics at the Providence Hospital, Washington, D.C.; Fellow in Pediatrics at the Mayo Clinic, Rochester, Minn.; and Fellow in Pediatrics (research) and Fellow in Psychiatry at the Johns Hopkins University, Baltimore, Md.



Sylvan S. Furman, before entering on his present position, was director of the National Health Forum on Urban Sprawl, National Health Council, assistant director of the New York City Community Mental Health Board, and director of community relations for the New York City Youth Board. Educated at Columbia College, the University of Vienna, Austria, and the New York (now Columbia University) School of Social Work, he has studied European mental health programs on fellowships from the Milbank Memorial Fund and WHO.



After 4 years in the public assistance division of a local county department of public welfare, Berta M. Brewster transferred to the department's child welfare division, as a caseworker and later as a case supervisor, working with children in their own homes, in foster boarding homes, and in adoptive homes. In August of 1962, she joined the fieldwork staff of the Albany Area Office of the New York State Department of Social Welfare. She is a graduate of the Syracuse (N.Y.) University School of Social Work.



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Evidence of a growing realization that the problems troubling young people in the critical period between childhood and adulthood require special attention, both for their own and society's sake, prompts CHILDREN to present the following two articles on adolescence. The first, based on a working paper prepared for the World Health Organization's Expert Committee on the Health Problems of Adolescence, outlines the interacting biological, psychological, and social influences which affect the developmental process in this stage of life. The second, beginning on page 136, while derived from a psychiatrist's practice, has pertinence for any professional person intent on helping adolescents deal with their problems.

A DEVELOPMENTAL APPROACH TO ADOLESCENCE

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ADOLESCENCE may be defined as a critical period of human development manifested at the biological, psychological, and social levels of integration, of variable onset and duration, marking the end of childhood and setting the foundation for maturity. Biologically, its onset is signaled by the acceleration of physiological growth and the beginnings of secondary sexual development, its termination by the fusion of the epiphyses of the bones and the completion of sexual maturation. Psychologically, it is marked by an acceleration of cognitive growth and of personality formation, both of which continue to be subject to further evolution, though at less marked rate, in subsequent stages of adulthood. Socially, it is a period of intensified preparation for the assumption of an adult role, and its termination signaled when the individual is accorded full adult prerogatives, the timing and nature of which vary widely from society to society.

Adolescence is a "critical period" in development, being both a time of rapid and profound change

in the organism and a time providing the necessary—but not sufficient—conditions for full maturation in adulthood. Optimal development in adolescence depends on successful accomplishment of the developmental tasks in infancy and childhood. Thus, clinical experience has indicated that adolescence is likely to be particularly stormy, prolonged, and sometimes poorly resolved if it follows a childhood marked by severe deficits.

Whether or not appropriate "experiential supplements" during adolescence can lead to successful negotiation of this period despite pathology in earlier life is not known. The heuristic hypothesis is to assume that repair can occur and that the task of the physician is to search for ways of encouraging optimal growth during the adolescence of a previously damaged child.

Although a rich, fulfilling adolescence provides the best groundwork for a successful adulthood, such an outcome is not automatic; it depends, in turn, on the provision of opportunities during adulthood for

the creative exercise of the abilities achieved in adolescence.

The structural groundwork for adolescent development is laid by physical maturation. This developmental sequence is not preformed or automatic but depends upon an interaction between biological capacity and environmental stimulation. Just as growth requires adequate nutrition—being subject to delay or even cessation in the presence of starvation and to acceleration in the presence of optimal intake—so psychological maturation is dependent upon “psychological nutrition,” that is, sequential opportunities for cognitive and social stimulation so timed that they promote further mental development.

Interdependent Developments

Thus, adolescence is simultaneously a biological, a social, and a psychological phenomenon. Development at each of these levels of integration proceeds not independently but with significant interaction, with events at any one level able to impede or to accelerate developments at each of the others.

For example, although the time at which the hypothalamic-pituitary axis initiates the biological sequence of adolescent growth is a function of individual heredity, it may, in a given individual, be delayed or advanced by environmental factors. Thus, the ultimate height attained by adolescents in economically developing countries has shown striking gains as nutrition has improved. Similarly, the time of menarche has shown a trend toward acceleration in countries in which increasingly better health of the children has been achieved. These physiological trends are the result of industrial and social organization.

Or again, biological maturation provides the increasing muscular strength and dexterity which permit the adolescent to participate successfully in the activities of his social group, thus acquiring a psychological sense of adequacy. At the same time, positive psychological motivation is a prerequisite for task perseverance and the search for variety of experience, which provide the conditions necessary for full muscular development through exercise.

Developments at the biological and psychological levels occur in a social framework, which may promote or retard them. Thus, unscientific notions about diet prevalent in a specific culture may lead to inadequate nutritional intake, and social prejudices against minority group members may deprive them of experiences necessary for full development.

The importance of such reciprocal influences is

underscored by the fact that each society is dependent upon its adolescents as its future adults. Failure to provide them with the conditions necessary for optimal development will severely handicap the growth potential of that society.

Biological adolescence has fairly precise signs of its onset and termination, such as growth acceleration, sexual development, and epiphyseal fusion, but there is remarkable variation in the timing of their appearance in different individuals. Onset in normal children may occur as early as age 7 or 8 or as late as 17 or 18; termination as early as 15 or 16 or as late as 24 or 25. The timing seems to be a function both of internal factors, such as sex and inheritance, and external factors, such as nutrition and illness. In other words, the biological factors set wide limits for the onset, termination, and achievements of adolescence, the potential limits being subject to modification by environmental influences among which both psychological and social factors play a role.

Social Preparation

Adolescence as a social phenomenon, though restricted in range by biological considerations, is a function of cultural norms. In general, the more sophisticated the society is in its technology, the more prolonged is adolescence, since the complexity of preparation required for the assumption of adult roles depends upon the demands the society sets. The United States, for example, the long period of study required for specialized occupational roles, the age of self-support, the opportunity for marriage, and the age of creative contribution to society—all attributes of the adult role.

In many cultures, the onset of adolescence is clearly signaled by puberty rites, usually in the form of tests of strength and courage, the completion of which entitles the individual to recognition as a young adult. In technologically advanced societies, the clear signification of the end of childhood is absent and the requirements for adulthood less clearly defined: the individual must, therefore, undergo a more prolonged and, at times, confused struggle to attain adult status.

Each culture provides experience specifically designated as part of the training of the adolescent, such as schooling and apprenticeship; other experiences, such as dating and courtship, which are for the most part limited to adolescence but are not formally organized; and other non-age-related opportunities for personal development which may be particularly

eaningful for the adolescent, such as opportunities to participate in cultural and political life.

Deliberate social planning based on a scientific analysis of adolescents' needs has been relatively neglected, the forms and structures society provides having evolved empirically. Only within school systems has such planning been explicit, but even there with little careful research. Yet careful assessment of the needs of adolescents at all levels of developmental integration could lead to the design and provision of external conditions that would greatly accelerate the rate, and markedly increase the ultimate level, of the development of the human adolescent's full potentialities.

be Idealism of Adolescence

At a psychological level, the most striking attainment during adolescence is the ability to conceptualize at an abstract level. The further evolution of what Piaget calls the "concrete operations" of childhood¹ through interaction with increasingly more demanding intellectual tasks, provided both by formal schooling and informal social experience, leads to the ability to "think about thinking" and to analyze problems at a high level of generalization. It is here that the *Anlage* of scientific thought and creativity to be found. This evolution of intellectual function requires appropriate environmental stimulation. The adolescent's capacity for abstract thought accounts for his increasing concern with, on the one hand, national and international problems and, on the other, with the basic meanings and values of man's existence. This "idealism" of adolescence is, of course, shaped by the cultural envelope which surrounds the individual, but its very existence leads to questioning, to examination of basic premises, and dissatisfaction with the imperfections in the world adults have created. Its cultivation may be regarded as one of the most important tasks of society.

Fostering and strengthening this "suprapersonal" psychological trait in adolescents will lead to the creation of adults who will in turn enhance the society that bred them. The lack of adequate opportunity for its positive expression will warp the adolescent's normal development and lead to a generation of self-preoccupied adults who will fail to meet the challenge of history.

Personal Identity

A second and related psychological theme of adolescence is the search for a sense of personal identity, to employ the terminology of Erikson.² No longer

a child and not yet an adult, the adolescent is busily engaged in determining who he is and what he is to become.

In this effort, he examines his parents from a more critical perspective and leans more to peer groups for his sense of belonging. If his relations with his parents have been soundly constructed during earlier years, and if they meet his doubts and criticisms with sympathetic understanding, this temporary unsettling of his prior role as a child leads to a resynthesis of his relations with them on a firm and lasting basis, one marked by reciprocal respect and by personal independence without abandonment of filial loyalty. Where the parent-child relationship has been one of excessive dependence or excessive hostility, the turmoil of adolescence may be prolonged and lead either to failure of emancipation or to rejection of family ties and a lasting sense of isolation.

Sexual Role

A third key developmental task consists of the further evolution of sexual identity and role-appropriate behavior. Learning the social role of one's sex is firmly rooted in childhood—in culturally differentiated role assignments, in emulation of the like-sexed parent, and in peer interactions. These experiences provide a constant feedback, both by comparison of the self with others and by praise or blame from them, which informs the child as to what sex he is and what kind of behavior expectations this entails. These preliminary psychological structures are challenged by the adolescent's consciousness of his development of adult sexual characteristics and his experience of a bewildering array of new physical sensations, both of which lead to an upsurge of interest in physical sex and a psychological sensitization to a new aspect of interpersonal relationships. The forces in the social field then determine the further steps in his sexual development.

Comparative studies indicate that, as the evolutionary scale is ascended, sexual behavior is less dependent upon hormones and more upon learning. In man, the role of hormones is limited to priming the organism for biological sexual maturation and to influencing—but not solely determining—the level of libido; the direction, nature, and adequacy of sexual performance are controlled by psychosocial factors. Thus, the many investigations of the biology of sex deviants have failed to identify chromosomal, hormonal, or gonadal aberrations; and conversely, individuals with such biological incon-

gruencies usually exhibit a sex-role identity conforming to sex-role assignment.

The remarkable variation in sexual behavior between societies as well as between social classes within a single society emphasizes the cultural determination of sexual behavior, given adequate biological maturation.

The ambivalence of Western society toward sexuality—manifested by the conflicts between official attitudes and private behavior, and the pervasive emphasis on sex side by side with sanctions against its expression—accounts for the difficulty, so common in adolescence, of attaining the basis for a sense of competence, freedom, and pleasure as a sexually functioning adult. Persons concerned with the development of adolescents have an important obligation to give them a clear and full explanation of biological function with emphasis on its *ethical significance* based upon a mutually meaningful relationship between human beings. Adolescents need a comprehensive knowledge of the physical and physiological differences between the sexes, of the development of sexuality, and of the appropriate stages of sexual experience en route to full maturity.

Commonly expressed fears that giving adolescents such information will lead to premature experimentation run contrary to clinical experience which indicates that ignorance and impoverishment of human relationships account for most sexual misadventures. A sense of inadequacy in sexuality not only impairs sexual function but also leads to disabilities in other adult roles and is an important source of psychological malfunction.

Origins of Delinquency

The search for identity is markedly influenced by peer groups. If these are constructive social groups which provide creative outlets for adolescent energy, the result is a sense of meaningful membership in the community and identification with its larger goals. If the peer group is a delinquent gang, with values antagonistic to those of the larger society, the result is likely to be antisocial personality organization—especially if the adolescent is a victim of discrimination for religious, ethnic, political, or economic reasons.

The experience of growing up as a member of a disadvantaged minority group, with attendant humiliation and denial of opportunity, makes it difficult for the adolescent to identify with the values of the society at large and favors, instead, hostility toward its norms and a disposition to anarchistic in-

dividualism. However, even under these circumstances, leadership and social forms which permit the disadvantaged adolescent to employ his energies in efforts to change unjust social patterns can foster his emergence into creative adulthood. If such opportunities for constructive social action are denied the distortion of development leads to a frustrating and progressively more embittering "individual war against society" characterized by criminal activities.

Some theorists focus upon family pathology in explaining the evolution of delinquent behavior. Their thesis is based upon the finding that family psychopathology is frequent in the history of delinquents. The family is indeed an important agent in transmitting the behavior pattern and values expected of the adolescent by society. Consequently, distortions in family structure, whether idiosyncratic or socially induced, will inevitably have profound effects upon individual development. However, the family-centered viewpoint fails to recognize that family psychopathology is closely related to social structure and that the adolescent is also molded by social experiences outside the family.

The social consequences of economic disadvantage—poor health and reduced longevity, poor education, extralegal marital arrangements, inability to plan for future contingencies, necessity for exploiting children economically—themselves erode family structure and are likely to cause the victim of these social circumstances, the genesis of which they do not understand, to turn on each other in destructive ways. The unemployed, drifting father and the unmarried, deserted mother not only fail to provide their children with adequate nurture but also serve as poor identification models.

However, even though family structure be distorted, the adolescent may attain a degree of normal development if provided adequate education and constructive peer group experience. Unfortunately, the aggregation of disadvantaged families in decaying neighborhoods is all too likely to reinforce family psychopathology and, by exposing the adolescent to delinquent gangs and ineffective schoolin, heighten his growing sense of bitterness.

Hazards and Symptoms

The sensitivity of the adolescent to the good opinion of his peers and the dependence of his sense of identity upon the attainment of competence in an adult role render him psychologically vulnerable to variation in physiological development, such as precocious or delayed growth, facial acne, obesity, etc.

larged mammary glands in the male, or inadequate or overabundant breast development in the female. These deviations from the expected pattern of maturation, though of no great medical significance, may, nonetheless, lead to major psychological trauma if not offset by sensitive guidance.

The adolescent with limited intellectual or physical capacity can develop a persisting and even irremedial feeling of inferiority if he is forced to compete in situations in which he experiences continual failure. The individualization of educational and vocational training for adolescents is essential, both to permit the talented individual to exploit his abilities, as well as to direct the youngster with specific limitations to activities which will develop what abilities he has.

Characteristic of adolescence is fluidity of psychological structure in the struggle to attain a new and more meaningful sense of identity. In consequence, the formation of transient symptoms, resembling many of the psychopathological syndromes of adulthood, is not uncommon during this period. The clinician must exercise great caution lest he attribute too great a significance to the turbulent but temporary maladaptive patterns manifested by the adolescent. Incorrect diagnostic formulations may lead to social consequences—for example, withdrawal from school or institutionalization—that will freeze into permanence an otherwise readily correctable deviation in the growth pattern.

It is, of course, important to recognize that schizophrenia often first appears in adolescence, as does manic-depressive psychosis. However, these are uncommon disorders and may be simulated by panic reactions in the youngster who is confronted by overwhelming internal and external stimulation. If the recent trend toward a specialty of adolescent psychiatry has any justification, it lies in the opportunity for psychiatrists to acquire particular competence in the differential diagnosis and special management of adolescents' adjustment reactions. Experience with the psychiatric problems of adolescents leads to respect for their extraordinary range of individual variability and their remarkable restorative capacity under corrective and supportive experience.

The psychological basis for a sense of individual worth as an adult rests upon the acquisition of competence in a work role during adolescence. A sense of competence is not acquired on the basis of "assurance," but rather upon the actual experience of succeeding in a socially important task. The chal-

lenge to the educator, therefore, is to stimulate abilities to the utmost without setting standards so high that they lead to an enduring sense of defeat.

The educational accomplishment must be matched by an opportunity for the individual to exercise his competence as a worker in the economic world. The sustained motivation necessary for mastering a difficult work role is only possible when there is a real likelihood of fulfilling that role in adult life and having it respected by others. The task of providing full employment in a world in which automation is revolutionizing traditional work roles provides a challenge to the abilities of leading thinkers in all societies.

The World's Hope

No society can hope to survive that does not succeed in harnessing the constructive, searching supra-personal and supranational drives of the adolescent. In recent world history, adolescents in underdeveloped countries have participated heroically in overthrowing the dead hand of the past and attaining the beginnings of a meaningful nationhood. The picture in the relatively developed countries is less clear and less heartening. As affluence is attained, societies tend to become frozen into traditional molds, with resultant trends toward self-preoccupation and egocentric goals that afford less challenge to adolescents. There are, fortunately, notable and inspiring exceptions to this self-preoccupation, as youngsters dedicate their energies to improving the lot of disadvantaged fellow citizens and to social betterment in underdeveloped countries far from their shores.

The capacity for engagement in meaningful social activity is clearly present in young people in every country of the world. The challenge to the behavioral scientist is to help his own country develop the forms and means to enable the adolescent to take a leading role in the struggle for the attainment of a world in which peace, freedom, and economic opportunity are omnipresent. No task is more suited to the adolescent. No task has greater potentiality for permitting the full flowering of his capacities.

Thus, the provision of an optimal framework for adolescent development is inseparable from the struggle to create a better world by helping to mold the citizens who will build it.

¹ Flavell, J. H.: The developmental psychology of Jean Piaget. Van Nostrand, New York, 1963.

² Erikson, E. H.: Identity and the life cycle. In Psychological issues, monograph 1. International Universities Press, New York, 1959.

A PSYCHIATRIST'S TECHNIQUES IN TREATING ADOLESCENTS

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ADOLESCENTS in increasing number are being referred to psychiatrists for evaluation or treatment. Because they are notably difficult to reach and to keep in treatment, working with them requires techniques in many ways different from the techniques used with adults or children. The following observations are based on my experience with about 350 adolescents, between the ages of 13 and 21. They are not presented as the only way to work with teenagers, but as measures which, in my experience, have generally proved successful and which therefore might be found useful by others.

The Initial Interview

One of the first difficulties encountered in psychiatric work with adolescents is that most of those referred for evaluation or treatment do not want to see a psychiatrist. Generally, the young person has heard that psychiatrists are for "crazy" people, and he resists being classified as such. Usually, the psychiatrist has been chosen by his parents through consultation with the family doctor, teachers, or friends, and the adolescent resents having to confide in someone who must be a parent ally.

All this makes the adolescent's first visit crucial to the success of the therapy. The therapist has to convey to him that *he* is the one the therapist is directly interested in helping, not his parents; that he is not crazy but has difficulties that can be helped if he will talk about them; and that what he says will remain confidential.

I have found that if I first see the adolescent before I have gathered any information about him, my initial contact with him is so spontaneous that he rarely resists confiding in me. I inform him that I know nothing or very little about his difficulties and I would like to hear from him what they are. If I still don't get much information, I ask him about the composition of his family, his friends, his hobbies, his school (all fairly neutral subjects), and then return to the question of why he has come to me.

Only toward the end of my first appointment with the adolescent do I ask him if I can see his parents to hear about their view of his difficulties. By this time, the adolescent's confidence has almost always been gained, and he offers little resistance to bringing his parents to my office. Asking him to bring them in himself gives him the satisfaction of "inviting" his parents to talk with me.

Occasionally, when the adolescent brings his parents to my office, he comes into the room with them. I make no comment about this and allow him to remain. For example, a 17-year-old girl had been very suspicious of me throughout my first interview with her. She did not believe that I had not been in touch with her parents and angrily refused to tell me the reason for her referral, saying that I knew it already, and asking why she should bother to repeat it. When she brought her parents to my office, she came in with them. I asked the parents what difficulties they were having with their daughter and then asked the patient how she felt about her par-

ents' complaints. She slowly came to realize that I had been truthful and had not previously been informed of her troubles. Before the end of my interview with her parents, she asked to see me again, but alone.

The Relationship

Once the first contact has been made with the teenager, how does the therapist involve him in treatment? Adults, if they want help, are ready to work in psychotherapy; children see the therapist as a playmate and enjoy the attention that the therapist gives them. But teenagers often do not see why they need a therapist and their motivation to work with one is often very weak.

For this reason, the therapist has to get the adolescent involved in treatment very quickly in order to keep him in treatment. The therapist has to work to create a positive relationship, and once this is established has to work at maintaining it. He has to avoid comments in the early sessions that sound like remarks the patient has heard from parents or from other adults with whom he is having difficulties.

I lost a patient a few years back because I told her in my second interview with her that she struck me as wanting to rule other people's lives. This was after she had asked me to sit in a different chair, to talk only when she asked me to, to look in one direction, to use a different lighting in the office. My remark was poorly timed. A positive relationship had not yet been established, and I created in her a strong negative reaction to me which I could not work with efficiently, not knowing enough of her history. She left me after three or four more interviews because she "hated my guts"—I was "just like her father."

It is important, however, not to be "too nice" in order to win the patient over. Adults rarely insult the psychiatrist when they start treatment—they come because they want to come. On the other hand, adolescents are often verbally assaultive when they first start working in psychotherapy, especially if they have been forced to come in some way. Although it is important to adopt a patient attitude toward their vindictiveness, the therapist should not respond with too much kindness. If he does, and if the patient is suspicious, the suspicions may be increased—"Why are you so kind to me when I am so nasty? You can't like me the way I act; you must want something from me" is a typical response.

I have worked, and still do, with a 13-year-old boy who in the early interviews called me "woman" or

"spy," and became more and more paranoid as the weeks went by. One day, wondering if my tolerant and warm attitude toward him might be making him suspicious of my intent, I decided to react more naturally to his nastiness and told him that I was fed up with being treated the way he treated me, that I did not especially enjoy working with him, but that this is what had to be, and so was. From this time on, the patient became less paranoid and slowly started relating to me. Later, he told me he had questioned my motives when I first saw him because my behavior was so unnatural that he felt he could not trust me.

In addition to building a positive relationship with the teenager—or in order to build it—the therapist has to come out of his own shell a little. The teenager is still in search of adults with whom he can identify and one has to allow him to know something about oneself in order to facilitate the identification.

Free Association

How does the adolescent work in therapy? Can he talk freely about whatever comes to mind, or, in psychiatric terms, "associate freely"? He can, but he will not go about it the same way as an adult. When he is overly anxious, he is most apt to be quiet. Rather than motivating him to confide, too much anxiety is apt to block his ability to communicate. He may feel engaged in a battle of wills with the therapist over who will give in and talk first—a struggle which the therapist would do well to avoid. I often tell the patient that I feel this struggle is going on, that I am not interested in winning a game with him, that I *am* interested in helping him and am ready to talk first if this will help him to talk.

Sometimes I ask the adolescent, "What's on your mind?" although adolescents' usual response to this question is: "Nothing." When this happens, I may point out that I realize that this question must be annoying, that I would like to find other ways to formulate it but cannot, and then I suggest that perhaps he, the patient, could tell me the kind of question it would be easier for him to answer. If said with sincerity, this has a magic effect. Not only does the patient communicate his thoughts, but the next time I ask him what is on his mind I have a feeling that he smiles forgivingly as he goes ahead with his answer.

In a few instances, in which a very angry patient has remained silent for a long period of time, I have allowed him to remain in my office but have glanced through a magazine as he sat there. After a while, I have made some comment about what I was seeing

or reading and soon the patient has joined me in talking about it. Thus the ice has been broken.

Sometimes I "free associate" with a nontalking patient. I tell him what I think might be going through his mind. Often, in such instances, the patient has interrupted my talking either because he has been surprised that I have read him well or because he has become angry at my projecting my thoughts on him.

When a patient is silent in an evaluation interview, I may ask him to draw a picture. I do this not only because I am interested in what he produces—which I am—but also because, as he concentrates on his drawing, he relaxes his efforts to ward me off and begins to talk more spontaneously.

Phrasing Questions

Adolescents are much more defensive than adults, and direct questions often reinforce their defenses. However, the therapist can get the information he wants by asking a question indirectly or even giving some suggestion of an answer in phrasing it. The question "How do you feel about not having any friends?" is rarely answered by "lonely." However, the response is usually frank if the question is phrased, "I wonder if at times you don't feel lonely, not having any friends?" If this suggestion reflects his feeling, the adolescent nearly always admits his loneliness and begins to talk about it; if he does not feel lonely, he does not hesitate to say so and will often voluntarily begin to talk about the way he does feel. I like to compare this technique with pump priming, a small but essential task in getting water to flow.

Teenagers are especially guarded about their sexual fantasies, feelings, and actions. Because this area is an important source of disturbance, it cannot be overlooked in therapy. However, the subject has to be approached gradually, by reminding the patient occasionally that this is an area that will have to be discussed sometime before the treatment is over, although there is no immediate necessity to talk about it now.

A teenage boy who was in treatment with me for a period of 2 years used to cancel his next appointment every time I broached the subject of his feelings about sex. After doing this three or four times, he came to realize that these cancellations were directly related to my attempt to broach the subject. Therefore, after my fourth attempt, he kept his next appointment, but came in announcing that he was going to stop treatment. I told him then that I felt he

wanted to avoid this important subject; that obviously he had problems in this area since he could not talk about it; but that if he wanted to stop coming for treatment, I could not keep him coming. At the same time, I told him that if he did remain in treatment I was going to increase my fee, since he was working now and could afford to pay more. To my great surprise, after a fairly long silence, he said that he had changed his mind and that he would remain in treatment. And he asked: "Can I start now to talk about sex?" He began then—and continued in several subsequent interviews—telling me about his sexual fantasies and experiences, which had deeply frightened him.

Independence

How does a therapist deal with the adolescent's need for independence? I do my best to enhance it in a practical way. If the adolescent is working, I often reduce my fee so that he himself can pay for treatment instead of relying on his parents. If he is not too disturbed, I encourage him to come to my office alone. I also do my best to schedule the appointment at a time which is mutually convenient for him and for me. I treat him as an adult who has his own rights and often call him Mr. — (or Miss) rather than by his first name.

The teenager must realize that although the therapist believes that he needs treatment and should, for his own sake, keep his appointments, the therapist does not need him in any emotional way, as too often his parents do. Moreover, the therapist must be careful not to act like a parent by doing things *for* him. If the therapist is tacitly or overtly encouraging the adolescent to work, or go to school, or to live away from home, he should beware of getting involved in the realization of the project. This must come from the adolescent himself. Too much zeal on the therapist's part may often end in a painful failure since any resentment or hostility the teenager has against the therapist may be expressed in an action to defeat his efforts. For example, job and therapist get linked instead of job and patient. How can a young patient more easily get even with his therapist than by leaving a job the therapist has taken pains to secure for him?

Acting Out

Adolescents in treatment are prone to act out their anxieties, sometimes with bizarre or threatening behavior. Parents often react to such acting out in kind: a therapist should not follow the same pattern

Teenagers often feel that the more they act out, the more attention they will get. This, unfortunately, is frequently the case, but the therapist should not encourage it. I am willing to see a teenager outside of regular appointment hours if he is genuinely upset, but I do not panic when a teenager phones me saying he has taken pills and is going to die. On such occasions, I have informed the patient that I could call his parents or the police and tell them to take him to the hospital's accident room and that would see him at the time of his regular appointment with me.

Acting out is sometimes part of the adolescent's scheme to be regarded as a "special patient"—a very sick patient."

For example, one day a teenage girl asked me what her diagnosis was and I replied, "adolescent situational reaction." She waited a while, then, to my surprise, pensively said, "I am sorry I am only that— even after the crazy things I have done." Her behavior changed drastically from then on.

If the adolescent develops a strong positive relationship to his therapist, this may limit his acting out. For instance, a girl who was in treatment with me for 2 years refused to finish high school after her discharge from a mental hospital. I told her that going on to graduate was a condition of my working with her and that, while I could not force her to do so, if she chose to continue in treatment with me she would have to go back to school. She did go back, graduated, and was accepted for admission to college. On the day she received the college acceptance, she telegraphed me: "Thank you for having insisted that I complete high school—I made it to college."

However, a therapist should not take a position if he is not prepared to see it through. Consistency is one of the great virtues of a good therapist. The patient has to know that the therapist means what he says.

be Patient's Parents

Honesty is an essential virtue in the therapist. I tell all my patients about any call I receive about them. I let them know at the beginning of my work with them that I will do this, and I carry it through consistently. I also tell them that I will not see their

parents without their permission. This has worked out very well. When crises have arisen, making it necessary for me to see the parents, I have always been able to get the patient's permission to do so.

Allowing the patient to express his anger toward his parents is part of any therapy. However, the therapist has to be careful not to side with the patient against his parents. I once almost lost a patient in treatment when I repeated what he had said to me that his mother did not seem to care for him since she had turned him over to the department of public welfare. For at least 6 months afterward, the boy refused to enter into a therapeutic relationship. He told me he hated me, that I was no good, that I wanted to hurt him, and, eventually, but much later, that I had insulted his mother. It took 6 months for him to tell me what I had said that had made him so angry. It is all right for the patient to denounce his parents, but it is a serious offense for the therapist to do so.

The advisability of seeing the parents of a teenager while he is in treatment has to be considered individually in each case. I do not make a habit of regularly seeing the parents. If the parents need support during their child's psychotherapy, I refer them to a colleague or a social worker. I do not want to become, in the adolescent's mind, a friend of his parents; I want to remain his own doctor.

Termination

The question of when to terminate an adolescent's treatment presents considerations different from those which are present in working with adults. In treating a teenager, it is not usually advisable to allow him to regress. The emphasis is on allowing him to grow up. Treatment should stop when the main issues involved have been worked through.

The teenager has to try his own wings. To keep him in the frame of psychotherapy for too long a period of time would impede his growing up. Therefore, as soon as I believe that a patient has reached a point at which he can handle his presenting problems without any help, I end the therapy, pointing out that if in the future he would like more assistance he may be able to get it then. I make it clear that I am now confident he can do well without me.

SUGGESTIONS FOR REFOCUSING CHILD GUIDANCE CLINICS

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A COMMENTATOR on metropolitan trends once wrote that the core cities of our Nation have come to be "the abode of the rich, the poor, and the slightly odd."¹ The rich can purchase relief from the stresses of living in the core city, and at the same time profit from its many advantages. The "slightly odd" are mainly those who do not have 2.2 children, or who dislike the conformity of the suburbs, or whose work demands that they live in town. The poor are mostly members of the unskilled working class, a large proportion belonging to ethnic minorities. Many of the poor are new arrivals to the city, such as the economic refugees from Puerto Rico, the social and economic refugees from the Deep South, and the "poor whites" from Appalachia. While all these new arrivals in the cities have adjustment problems, most of them need relatively little professional help. Opportunity is what they require, and many are making splendid progress, as did their predecessors—the great waves of immigrants of the past.

However, any large mass of people under stress is bound to contain many families and children who need specialized help. Their problems are aggravated when they are locked into the city's crowded core, as are large populations of the poor today, who

are experiencing environmental pressures somewhat different from those experienced by the immigrants of the past. They cannot move onward, or upward because of reduced open spaces, high costs of living, dwindling demands for unskilled labor, and racial discrimination in employment and housing. The resulting frustration is reflected in today's rising crime and delinquency rates. It is compounded by the inadequacies in the organization and administration of children's services.

Working in New York City's central borough of Manhattan, a prime example of a city's core, the Manhattan Society for Mental Health has a particular concern about the availability of outpatient psychiatric services to children of the lowest socioeconomic groups.

On the basis of Hollingshead's socioeconomic classification, as applied in New Haven, Conn.,² about two-thirds of the core-city population (unquestionably more in Manhattan) are in Classes IV and V—the semiskilled and unskilled, marginal, and dependent groups. This population contributes much more than a proportionate share to the caseload of the courts, juvenile institutions, jails, mental hospitals, child-caring agencies, and the rest of our social and public health services.

In 1963, the Manhattan Society for Mental Health (with support from the Field Foundation) undertook a year-long study to learn whether children of Classes IV and V in Manhattan were getting

Based on a presentation to the general staff meeting of the Catholic Charities Guidance Institute, Archdiocese of New York, September 1964.

heir share of psychiatric clinic services.³ The society ought answers to the following questions:

- *Recognizing that there is a scarcity to begin with, which children are getting whatever service is available?*
- *How does this relate to their socioeconomic status?*
- *Are children of low socioeconomic status getting reasonable share of the service?*

In the course of the study, data emerged on the question of *who tends to serve which socioeconomic classes.*

The study consisted of three parts: (1) analysis of a year's statistical reports of all the outpatient child guidance clinics in Manhattan; (2) detailed study of the waiting list of one voluntary clinic which has a stated policy of serving children of low socioeconomic status; and (3) a series of 40 field interviews with persons in the community who are most likely to be seeking psychiatric help for children, such as teachers, school guidance personnel, ergymen, court workers, and the like.

ases Treated

We found that during the year 1962, a total of 851 children under 18 living in Manhattan were served in some direct way by the outpatient clinics in the borough. Of these, only 828, or 14 percent, actually received treatment, as defined by the clinics themselves. The others received diagnostic services briefly and such other kinds of attention as psychological testing for administrative or educational purposes.

Looking for reasons why only 14 percent of the children seen received treatment, we tested the assumption that the rest of the clinics' time went into consultative work with schools, courts, and other agencies in order to help them do their jobs better.

However, our interviews with the people in the community who seek clinic care for children indicated otherwise. Interviews with referring sources revealed a strong and consistent sense of frustration in regard to the mental hygiene clinics—their intake practices, policies, and services. If the clinics had been doing useful diagnostic and consultative work in relation to the 86 percent of the children who were not treated, either the referring sources did not appreciate it or did not know they were receiving it.

Among the clinics that provided the most intensive treatment to children (as measured by average num-

ber of interviews per case), the average number of interviews per case was six, thus raising the question of whether the clinics handled a large number of cases with brief, nonproductive contacts. The data showed that the majority of cases that received six or more treatment interviews involved children living in the better off neighborhoods.

This led to the question of who was actually served. In relation to the total population, we found that the children of the poor, especially the "poorest poor," received proportionately less service than children of higher status families.

Who Serves Which Children?

On the question of which types of clinics served which kinds of children, we found that, by and large, the clinics under voluntary auspices (even those supported in large part by public funds) tended to serve the economically better off children, while the poorest children were served mainly by public agencies such as city hospitals, the school system's own child guidance clinics, and juvenile court clinics. Agency auspices are not supposed to make any difference in quality of service or population served. Nevertheless, they clearly do. The voluntary clinics served about one-quarter of all the children seen in the clinics, but treated three-quarters of all children who received treatment—again the economically better off from the better neighborhoods, those most likely to be what Caplan⁴ has characterized as the "good" cases.

Corroborating this, the study of a waiting list—a source of great irritation and frustration to those who make referrals—indicated that the self- and family-referred cases on the list were most quickly accepted for treatment, while the court- and police-referred cases had to spend the longest time waiting and often, because of changed circumstances during the waiting period, were never reached. Thus, the waiting list itself was revealed as only a pool from which cases are selected for treatment, with the most troublesome and potentially harmful cases to the community tending to remain on the bottom.

The existence of two systems of clinic care was thus demonstrated, one under public and the other under voluntary auspices. The system under public auspices is relatively nonselective, more overloaded, and gives a somewhat curtailed service. Its clients are almost exclusively children of lower socioeconomic status. Most of them are referred by public schools and the courts. The system under voluntary auspices, but supported by a good deal of public

money, serves patients of higher socioeconomic status, mainly self-referred or from medical sources, and is much more selective about the children it accepts for treatment.

There may be good reasons for having more than one system of care. Even so, the two systems, taken together, should constitute a pattern that covers community need. The present picture indicates seriously inadequate planning, inappropriate or narrowly focused services, and, in some cases, self-delusion on the part of the community and the mental health professions themselves. Furthermore, the same inadequacies are surely demonstrable in almost every other American city.

Neglect of Urgent Needs

There has been an alarming increase of children entering State mental hospitals over the past few decades, but little organized effort to do much about it. Between 1888 and 1910, there was only one admission of a child under 15 to New York State mental hospitals. Ten years later, there were 21 in one year. In 1950, there were over 250. And in 1963, there were almost 1,600 child admissions. Estimates based on present trends in New York State are that the 1963 figure will be increased by over 100 percent by 1970.⁵

The outpatient clinics do not seem to try to cope with the problem of seriously disturbed children, but concentrate their attention on children with milder disorders. Yet the future problems engendered by placing children in large mental hospitals are apt to be complex and intractable. Once a child enters a State hospital, he is likely to remain there much longer than an adult and to present much more difficult aftercare problems.

When the increase in child admissions to mental hospitals is considered, along with parallel trends in juvenile delinquency statistics and other indices of emotional disturbance, the impression is strong that most of our psychiatric services for children are being aimed at the fringe of the target, not at the center. If this is so, merely to expand services as they exist will not solve the problem. Practical, meaningful help must be directed to the "bad" cases; in addition, help must be given to all the other health, welfare, and correctional agencies of the community that try to cope with such cases. Of course, the clinics alone cannot be expected to do the job of preventing serious emotional or social breakdown: a broad range of health and welfare services for children is needed. Nevertheless, the first obstacle to

effective participation by children's psychiatric clinics is that many of their approaches are simply inappropriate to the needs of the children of poverty-stricken families.

What is needed is a far higher priority of concern about the poorest children on the part of the mental health professions. If these professions are to be socially effective, they must adapt their clinic methods to the needs of these children. They must also make greater efforts to bring their mental health concepts to the aid of the basic community health and welfare services, and thereby spread the effects of their knowledge to the agencies which bear the brunt of people's problems. They must participate in forming the kind of interagency network that will not have holes in it large enough to screen out children needing service.

Applying Concepts

Mental health services are not a panacea for all the ills that befall children. Nevertheless, they can have broad impact on children's health and welfare if used more creatively and more economically.

Our institutions for neglected children contain many damaged children, but they do not all need to be turned into little psychiatric hospitals. The need, basically, to be better child welfare institutions with consultative help from the mental health professions.

By the same token, it is neither necessary nor appropriate to convert juvenile probation departments into psychiatric clinics. Admittedly, most such departments do need additional clinical services, but primarily they need more good probation officers better trained (with the aid of the mental health professions), and better paid. The courts also need more help to enable the judges to do their own work more effectively. With this, the judges and probation officers would be able to make better use of clinical services.

But to accomplish this, the clinics, in the first instance, need to be more interested in the problems of the most beleaguered portions of our population and more active in giving help with *particular understanding of the social class factors involved*.

In addition, since no agency ever has enough funds or personnel to serve all comers, it is imperative to establish a *system of care* in each community or defined service area, so that available, appropriate help is directed to deviant children soon enough to be effective.

Such a system would provide a wide variety of

easily accessible services, in accordance with the needs of the child—and of his family, for the two are inseparable—with the rapid assumption of responsibility for the case by the system of care, *no matter what the presenting problem*.

At the present time, procedures in seeking help for disturbed children place an unwarranted and unreasonable burden of responsibility on the applicant or on the referring source. In effect, the referring source—whether teacher, a clergyman, or a parent—is expected to be sophisticated enough to refer the child to the service especially suited to his problem; he is expected to be able to decide whether the situation requires child welfare, psychiatric, or family services. In a large city, with numerous independently operating agencies, this is a high expectation. If the referring source applies to the wrong type of agency, he is given the unfair burden of shopping around for the right kind. Sometimes he is given advice, but the problem is left with him, so that he becomes frustrated or hostile and rejecting of professional services, or else makes an inappropriate approach to the next agency, thereby compounding the problem—all at the expense of the child who needs help. Too often, he just gives up.

Waiting List or Defense?

The matter of the eternal waiting list needs immediate attention. If mental health agencies consider their services to be preventive of mental illness or deep emotional disturbance, it is paradoxical for them to ask the client to make himself available at the point of the agency's readiness, rather than his own. At the time he applies, the applicant is likely to be at a relatively high point of readiness to work toward solving his problems. His application represents some kind of awareness of crisis—actual or pending. He may then be as ready to participate in attempts to change the situation as he ever will be. Yet he is asked to wait for periods that are sometimes ridiculously long, and this is rationalized on the basis that if he is "really motivated," he can withstand the stress.

Intervention at time of crisis is said to be most effective. Does not this imply that speedy contact with the client is likely to result in more productive, even briefer service? Would not the agency thus be able to serve more clients per year?

Clinics should ask themselves a number of questions in connection with the waiting list problem. Why should the standard time for an interview be an hour, or even 45 minutes, as in psychoanalysis?

Is psychoanalysis an appropriate operational model? Is it necessary or even desirable in every case? If many clients have a low tolerance for waiting lists, perhaps there are many with low tolerance for long interviews as well. Would it be possible to determine which clients could benefit from briefer interviews? Or, to put it another way, is it a fact or just an assumption that shorter interviews will be of less benefit to the client?

Then there is the question of when to terminate the case. The average duration of a case in psychiatric clinics in New York City is between four and five interviews.⁶ A great many cases are terminated by the client rather than the therapist. This fact should be faced. It might be productive, for example, to experiment at the outset with client-therapist planning in regard to how many interviews shall be offered.

Cooperation for Efficiency

Interagency relationships require some scrutiny. At present, referring sources often terminate their own service to a child or his family on the basis of "giving the clinic a free hand." Or the clinic may not wish the referring agency to continue its contact because this might "interfere with psychotherapy." Meanwhile, the patient may fail to benefit from psychotherapy because he also needs some kind of supportive, stress-relieving service that the referring agency can give as a supplement to psychiatric treatment. There seems to be a good deal of room for exploration of the possibilities of cooperative work without anyone having to surrender jurisdiction, prerogatives, or standards.

Another potential for expanding actual service might be realized by taking a hard look at the concept of the clinic team. Are so many interdisciplinary conferences needed? Is the intake worker given enough authority to make commitments for the agency? Is the patient put through a series of interviews and tests when the kind of treatment needed is fairly apparent from the outset? How much would actually be lost through rapid decision-making and case assignment?

Many of these questions could be resolved by planning in relation to a *system of care*, as opposed to an individualistic, agency-focused policy. This would change the tendency to evaluate the applicant in terms of whether he fits the agency, to evaluation of what he needs, how it should be supplied, and where the services can be found. This kind of perspective calls for consideration of such mechanisms as joint

interagency intake or evaluation services, through which a variety of children's services can be supplied as needed without the delays and frustrations caused by interagency referral for more intake interviews and independent evaluations.

Rationalizing Services

A positive approach to the many problems children present today would accordingly embrace these principles:

1. The need for increased efficiency in psychiatric services to children in a given community requires thinking in terms of a comprehensive system of care which offers a wide range of social, psychiatric, and health services that flow into each other and makes it possible for the *community's system to assume continuing responsibility for service*, no matter at what point the client makes his first contact. Thus, a child guidance clinic should be concerned not only about psychopathology and psychotherapy, but also about whatever service is needed to restore equilibrium to the disordered child or family.

2. In planning therapeutic approaches, both community and child can benefit from *speedy intervention in time of crisis and for relatively brief periods*, sometimes limited to supportive help, the duration of which may be determined in advance.

3. When the clinic cannot accept primary responsibility for a case referred, it should provide *case consultation and guidance to the referring source* or to the agency carrying the primary responsibility for the case.

4. From the standpoint of internal administration, the *concept of the "team approach" should be re-examined*, in order to learn whether cases may be taken on more speedily by giving more responsibility to individual workers. This implies experimentation in classifying forms of intervention that can be offered by the clinic or other agency and in the immediate assigning of cases for appropriate help.

5. *Clinics should be easily accessible to all agencies* in the community having concern about children and families, and should provide them with *practical, program consultation*. Thus, the clinic would seek not only to supply intensive, continuing therapeutic effort to a selected group of cases for well-defined reasons but would also help generally to improve

service for children who need and can benefit from other types of help.

6. *Decisions of clinics or other agencies about helping in a given situation should not be based on "either-or" thinking*, but rather on answers to the questions: "What kind of help can we give? What order of responsibility shall we accept in this case? What kind of help can we find?"

The Will To Help

In addition to a good deal of soul searching and willingness to adapt to new circumstances, these principles may call for the surrender of some time-honored customs and jealously guarded prerogatives. They call for skilled, rapid decision-making at intake. They may call for joint intake services, or at least joint evaluation, by clinics and family and children's services, and certainly for closer operational ties among all child welfare and family services. They may well call for some kind of central record keeping system. They call for continued interest in cases not accepted for treatment and willingness to supply more consultation services to other agencies, so that referral of an applicant elsewhere is truly referral and not simply disposal. They call for constant self-evaluation and self-criticism, as new devices are created and tested.

These are not easy means to adopt, but the results would be worth the effort. They would make mental health services a much more vital and broadly useful force in the community's total effort to serve the needs of children.

¹ Whyte, William H., Jr.: Are cities un-American? *Fortune Magazine*, September 1957.

² Hollingshead, August B.; Redlich, Frederick C.: *Social class and mental illness: a community study*. John Wiley & Sons, New York 1958.

³ Furman, Sylvan S.; Sweat, Lili G.; Crocetti, Guido M.: Social class factors in the flow of children to outpatient psychiatric facilities. *American Journal of Public Health*, March 1965.

⁴ Caplan, Gerald: An approach to community mental health. Grune & Stratton, New York. 1961.

⁵ New York State Department of Mental Hygiene Statistical Service, Albany. Unpublished reports.

⁶ New York City Community Mental Health Board: Characteristics of terminations for the psychiatric clinics in New York City. Annual Reports Series No. 6. 1961.

EXTENDING THE RANGE OF CHILD WELFARE SERVICES

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FOR THE PAST 2 YEARS, public welfare departments, stimulated by the 1962 Public Welfare Amendments to the Social Security Act, have been making important moves to extend the scope and range of services available to families and children. In New York State, where foster care and adoption services under public auspices were already available throughout the State when the amendments passed, the goal has been to make four other types of services similarly available on a statewide basis: family counseling; protective services; homemaker services; and family day care. These have been selected as the services most needed and most appropriate for adding to the programs of local welfare departments.

When such a significant extension in program is proposed on a statewide basis, it is necessary to begin slowly and to test theories about how the new services might be integrated with those already operating. The device the State welfare department selected to accomplish this testing was a pilot project through which the four services would be added over a period of several months to the program of a local public child welfare agency—specifically the Children's Division of the Rensselaer County Department of Public Welfare. Introduced gradually by the agency, the four new services were eventually combined in a newly organized unit, known as the Home Services Unit, which has now been in operation for 2 years. The experience in developing these services and the problems encountered in the process have brought up

some questions for consideration as the broadened program is introduced throughout the State.

The Rensselaer County Department of Public Welfare serves a half-rural, half-urban county of approximately 140,000 population, which covers an area 35 miles long and 25 miles wide. At the time the project was initiated, the Children's Division, under the general supervision of a division supervisor, was divided into three units designated as Intake, Under Care, and Homefinding and Adoption. The division was caring for 836 children, of whom 310 were in foster care, 496 in their own homes, 10 in adoptive homes, and 20 in a variety of other types of care. The Under Care Unit was responsible for services to children in their own homes as well as to children in foster care.

Homemaker Service

The first of the new services to be initiated through the project was homemaker service. The initiating stages took approximately 2 months. On request of the commissioner of the local welfare department, the county board of supervisors created three homemaker positions in the noncompetitive civil service classification, establishing a salary rate which ranged between the rates for clerical and casework staff, and, in conjunction with the Rensselaer County Civil Service Commission, prepared a duty statement for the future incumbents. A plan for the operation of the homemaker service was then devised and submitted to the New York State Department of

Social Welfare for approval, since the project was to be supported largely by State and Federal child welfare services funds.

A supervisor from within the agency was assigned to the newly created homemaker service on a half-time basis, her duties to include recruitment and training as well as supervision. The request to the New York State Department of Social Welfare for financial support included reimbursement on salaries only. No request for transportation funds was made.

After approval of the plan by the board of supervisors, the county civil service commission, and the New York State Department of Social Welfare, a recruitment ad was run in the local newspaper. Enough women responded to allow for choice, and three were selected as the first homemakers. They were placed on staff in late April of 1963. Except for one replacement, the homemaker staff has since remained the same.

Training. The newly recruited homemakers were given a 1-week course of group training by their supervisor. This included orientation to the agency with interviews with agency personnel; a field trip to a child-caring institution within the area; introductions to visiting nurses from the local public health department; a meeting with a home economist, who discussed meal planning and the use of surplus foods; and orientation to the job of homemaker through the use of material prepared by Rutgers University.¹ At the end of the week the homemakers were told about the situations in the families they were to serve, introduced to the caseworkers assigned to these families, and introduced to the families themselves through home visits.

Supervision. Since the beginning, the homemakers have met with their supervisor individually every week, and as a group once a month. In the individual conferences, the caseworkers assigned to the same case as the homemaker have been brought into the conference when appropriate.

The group meetings have been used to convey information of an administrative nature and for continued training. Pertinent literature has been read and discussed. The homemakers themselves have in many instances suggested subjects which they would like to be the focus of future conferences. These meetings have not been used to discuss individual situations in which the homemakers have been involved.

Some Figures. In the 2 years since the service began, 34 families with 176 children have been served

by the homemakers. Analysis of these 34 families shows that 25 were referred from within the welfare department—18 from the Public Assistance Division and 7 from the Under Care Unit of the Children's Division—and 9 were referred from outside the agency. Two of the out-of-agency referrals came from hospitals and one from a mental health clinic; the other six were self-referrals.

Of these 34 families, 19 were 2-parent families though in 7 the mother was temporarily away because of illness; in 8, the mother was pregnant; in one, the children were being neglected; and in 3, the parents had inadequate child-care standards. In the 15 1-parent families, the parents had been long separated by death, divorce, incarceration, or other circumstances. In seven of these, the father only was present; in eight, the mother only. In the latter three of the mothers had insufficient child-care skills and five were handicapped by pregnancy or illness.

A review of the case records reveals that the homemaker service kept 144 of the children from being placed outside their own homes. The 20 children who had to be placed in foster care in spite of having received homemaker service belonged in 4 families—in 2, the lone parent had to be placed in a mental hospital; in 1, he, a stepfather, discontinued the service and in 1, the father's working hours made it impossible to continue homemaker service until the mother returned from a hospital. In three families in which the homemakers were sent in to teach the mothers placement was never an issue.

The Service. The service has been used both to provide mother substitutes in emergencies and to train mothers whose child-care skills are inadequate. In some cases, both types of service have been provided, in the sense that upon the mother's return from a hospital the homemaker's role has become, in part at least, a teaching role. An analysis of the hours of service given the first 21 cases shows that in spite of the fact that over four times as many cases primarily involved substitution for the mother, only 62 percent of homemaker hours were devoted to the mother-substitute cases, the remaining 38 percent being devoted to training and teaching.

The hallmark of this program has been flexibility. The ability to assign homemakers full time, part time, for irregular hours, and to a variety of situations has accounted for a large part of its success.

The agency has also found the availability and quality of supervision for the homemakers to be of utmost importance, since these women work long

hours in situations which are invariably difficult and taxing, and need a supervisor's support.

However, the undertaking of both types of homemaker service—mother substitution and training—has caused some difficulty. In some instances a homemaker has been involved in a program of training with a mother when the need for her services elsewhere as a mother substitute in an emergency has arisen. The interruption of the training program has resulted in a loss of ground in the first mother's training. A larger program with more homemaker staff would reduce, if not eliminate, this problem, making it possible for homemakers to specialize in one or the other type of service.

No records have been kept regarding the number of children and the number of referrals made for which no homemaker was available. However, it has not been necessary so far to place any children in foster care because a homemaker has not been available. In some instances, the supervisor has referred families needing home help to the agency's employment counselor, or directly to persons who have expressed interest in becoming homemakers. In these situations, the homemaker does not have agency supervision nor is casework provided to the family.

Family Counseling

In August of 1963, both family counseling and protective services were initiated and the Home Services Unit established. The supervisor of homemakers became the unit's full-time supervisor.

The family counseling service—or "preventive service," as it is known in the agency—began with one full-time caseworker, but a second was added before a year was out. This service was designed for families seen in the Intake Unit, the Under Care Unit, and the Public Assistance Division whose problems seem to have "potential for change" under intensive long-term casework treatment.

Facts and Implications. In the 21 months since the inauguration of the family counseling service, 35 families, with 147 children, have received casework service. However, because of the travel time involved and the intensive nature of the service, individual caseloads have never been more than 17 families (67 children) during any one month.

The question of placing the children in foster care has been one of the most frequent issues to bring the families into counseling or to arise during treatment. Nevertheless, only 10 children from these families have been placed in foster care, and, of these, 8 have

since returned home. Most of these placements were necessitated by temporary family emergencies. In two instances, however, the child has required long-time foster care because of emotional difficulties in which unresolved interpersonal problems in the family have been intimately involved. In one situation, two children in foster care at the time the family was referred for counseling service were enabled to return home as a result of changes brought about in the family in the course of treatment and the use of homemaker service.

Some Lessons. In the first 10 months of the counseling service, one of the workers used 21 different community resources in helping the families in his caseload—a point which underscores the fact that an effective counseling service does not, indeed cannot, operate in a vacuum. Some of the resources used were available within the agency itself, such as work relief, employment counseling, and surplus foods. Others, such as legal, mental health, and medical facilities, were available in the community.

While "potential for change" has been one of the criteria for selecting cases for the counseling service, the staff has had to alter somewhat its original idea that this must involve an obvious motivation for change on the part of individuals. The families served have on the whole been of low socioeconomic status, with little education, and as a consequence have had difficulty in understanding the purpose of the service. They frequently have not been able to comprehend readily that anyone would be genuinely interested in helping them with their problems on a continuing basis. Rarely has a family requested the agency for help with a problem recognized as one it could do something about—more often the recognition has come from an agency staff member. Consequently, the process of engaging the clients in a continuing relationship has required a high degree of skill and patience on the part of the workers. Much remains to be learned about effective techniques for providing long-term casework for persons not geared by education or experience to seek and use it.

Protective Service

One worker in the Home Services Unit carries full responsibility for the protective service. This service focuses on cases of serious neglect or abuse in which immediate harm to children is threatened. The protective worker works with the family to secure improvement in the home or make other arrangements for the care of children. He is expected to

involve the authority of the court when this is necessary to secure adequate protection, care, and treatment of children whose parents are unable or unwilling to use the help offered.

Protective cases come primarily through the Intake Unit of the Children's Division, although occasionally a case being carried in the Under Care Unit, in which a critical situation has arisen, is referred for the service. In spite of a 1964 State law requiring doctors and hospitals to report cases of suspected child abuse to the public welfare department, only two referrals for protective service have been received from this source.

Protective Caseload. During the first 21 months of service, 33 families, involving 116 children, were referred for protective service. While the service plan set 25 cases as the maximum caseload, the highest number carried in any one month has been 21 families (72 children).

Of the 72 children in these families, 18 from 9 families have gone into foster care, and, of these, 12 are expected to remain in long-term care. In two cases (five children), work with the family is now geared toward obtaining surrender of the children by the parent or parents.

Some Findings. While it was anticipated that the protective service worker would deal frequently with the family court, this has not been the case. Thus far, all the children who have had to be placed outside their own homes have been placed with the voluntary consent of their parents. This is due to the skill of the protective worker in interpreting to the families the need for the children's placement. However, it is recognized that an effective protective service requires a close relationship with family court, and it is expected that the court's authority will need to be invoked often in future cases.

Another anticipation that has not materialized is that most of the protective cases would be short-term cases, carried by the protective worker only until the acute crisis was resolved, then either closed or transferred to another unit of the department. The worker has in fact carried many cases over long periods of time. Three factors have been behind this: (1) while the worker's intervention has in many instances resolved the crisis, it has not eliminated the need for intensive service, and a change of workers has not seemed wise after a relationship has been established; (2) the worker's caseload has remained small enough for the non-acute cases to be retained without detriment to those still in a critical state;

(3) the large caseloads in the Under Care Unit make it unrealistic to transfer cases there which still need intensive service. However, a number of cases have been transferred to the family counseling service.

While the protective caseload has built up gradually, it has burdened the worker with the special strains inherent in a service which is provided on an involuntary rather than a voluntary basis. A protective worker struggles constantly with the problem of evaluating the factors in the home which could be strengthened to preserve the home for the child, and those which are having negative effects upon the child. The constant focus in each case must be on the question of whether a meaningful home is being preserved for the child or whether a child is being allowed to remain in a damaging situation. This, of course, is an issue to some extent in all welfare services involving children. However, the protective worker carries a caseload in which that pressing question is the critical issue in every case and in which the clients are all involuntarily subjected to his services. Progress in such cases is slow, when it occurs at all.

The agency's experience has underscored the importance of supporting the protective worker with highly skilled supervision. It has also raised the question of whether it might not be desirable to vary the worker's caseload so that he could have some relief from the heavy strain involved in protective services.

Family Day Care

In June of 1964, the family day-care service was initiated by a newly assigned worker in the Home Services Unit. The worker's first assignment was the compilation of data pertinent to family day care and the development of a statement describing the program as it would operate in Rensselaer County including the types of situations appropriate for referral, the extent of service, rates for service, and referral procedures. The statement was used to acquaint the department staff and the staff of other community agencies with the program.

As soon as the program was announced, two families were referred for the service by family counseling workers, one by the local child guidance clinic and two by the department's Public Assistance Division. After about 3 months, the Public Assistance Division was asked to review its entire caseload and estimate the number of children for whom family day care would be an appropriate service. The result was 75 children from this source alone.

Homefinding. Five months elapsed from the initiation of the program until the first child was placed in a family home for care during the day. Lack of experience with this kind of program led to a tendency to approach recruiting in the same manner as boarding home recruitment. It therefore reached a frustrating point in which a few homes were available and ready and a few children were waiting for the service, but, because of distance between the children's homes and the day-care homes, no service could be initiated. Eventually, however, the agency devised the more successful technique of recruiting for homes in specific areas for specific children known to need the service.

The family day-care worker had spent considerable time studying the homes of five women referred as possible day-care mothers by various units of the department. Two were approved, but they lived so far from the children for whom care was needed that the day-care placements could not be made. Therefore, an advertisement was run in the local newspaper for 3 days, outlining a specific area within the city in which homes were needed. A total of 21 responses was received.

The agency responded quickly to all inquiries received from the newspaper publicity. With the exception of three screened out in the first telephone contact, an appointment for a home visit within a week was made with each respondent. While this worked well, the agency decided to include in future newspaper recruiting advertisements a time and place for a group meeting rather than urging applicants to contact the office individually. This not only provided a natural screening process which eliminated persons with only superficial interest, but also an opportunity to explain the elements of the program to everyone at the same time.

Staff and Procedures

Programs cannot be broadened in any way unless competent staff are available to carry out the additional services. The fact that they have been available for the Rensselaer County home services project is due to the New York State Department of Social Welfare's long-established educational program for child welfare personnel. Under this program, qualified persons are provided with stipends for professional social work education in exchange for a commitment to work for a specified period in a public welfare agency within the State as assigned by the State department. The new trainees, therefore, have been designated as the State's source of the personnel



Homemaker service in action. This is 1 of 4 important child welfare services recently added to local welfare programs in a New York State county, as described in this article. The other 3: family counseling, protective services, family day care.

needed in its plan to help counties develop home services, and it was from this source that the four workers were secured to provide the protective, preventive, and family day-care services in the Rensselaer County project.

The coupling of the professional training program and the development of home services has heightened the value of the former and improved the quality of the latter. It has provided newly trained persons with the kind of challenging assignment most likely to develop a lasting personal commitment to the public welfare field.

Flexibility has had to be the keynote in the Home Services Unit's administrative policies. Early in the program it became clear that the counseling and protective services cannot be provided effectively if working hours are limited to the agency's regular hours. Parents have to be interviewed after their working hours, children after school. Therefore, both the protective and family counseling workers schedule one full evening a week for such interviews. On the day of their evening appointments, they are permitted to start work at noon. Compensatory time for overtime work is also allowed on other occasions when interviews must be scheduled outside regular hours.

In planning the worker's caseloads, distance and travel time are taken into consideration, since the service covers an entire county of 875 square miles.

The fact that the Children's Division has excellent intake personnel and procedures has been basic to the success of the project. When requests for counseling service or family day-care services come from outside the welfare department, the intake staff makes a thorough study of the situation before referring the case to the home services supervisor for assignment to a caseworker. When such requests come from the Public Assistance Division or another unit of the Children's Division, the intake worker discusses them with the supervisors of the referring units before acceptance for the service. Requests for homemaker service are referred by the Intake Unit directly to the home services supervisor for evaluation and assignment. Referrals, from any source, of cases seeming to require protective service are the subject of immediate consultation between the intake supervisor and the home services supervisor. The latter makes the casework assignment without any further investigation.

Coordination of Services

The presence of the Home Services Unit has brought about a noticeably closer working relationship between the Public Assistance Division and the Children's Division. Requests from the Public Assistance Division for service from the Children's Division in the year beginning August 1, 1963 (the period when most of the Home Services Unit's services got under way), were double those of the previous year. The existence of the Home Services Unit may have been only one factor in this increase, but it undoubtedly was a potent one.

Eleven of the first 18 family counseling cases and 11 of the first 25 protective service cases were carried cooperatively by the Home Services Unit and the Public Assistance Division, and the trend has continued. The work in these cases was characterized by close cooperation and frequent conferences. Conferences on public assistance cases in which homemakers have been used have also multiplied the contacts between the two divisions, as have the referrals for family day care. Thus, significant inroads have been made in the traditional attitude of coolness between these divisions.

In the past, a critical situation in a public assistance case often resulted in a request for placement of children on an emergency basis. Now, however, child welfare services are sought more often in relation to homemaker service, counseling, or protective services. There has been a noticeable reduction in requests for emergency placements.

In addition to providing a better quality of services, the work of the Home Services Unit has had the effect of teaching, by demonstration, some professional attitudes and approaches. The positive effect of this, while subtle, can be detected increasingly throughout the department in a pervasive attitude of service to the client and willingness to cooperate with others in the agency.

Effect on Foster Care

Placement of children away from their own homes has, of course, continued to be necessary in many cases. But in these cases the placements can be made with better planning because of the presence of a wider range of services.

While referrals to the division have nearly doubled since the beginning of the program, the placement of children in foster care has dropped sharply. From April 1, 1962, to March 31, 1963, the year immediately preceding the initiation of the new program 593 children were referred to the Child Welfare Division, of whom 104 were referred to foster care. But from April 1, 1964, to March 31, 1965, the second full year of the program, 1,014 children were referred to the division, of whom only 79 went into foster care. As other services have been available placement in foster care has become more of a specialty and, in practice, more treatment oriented. With this development, increasing emphasis is now being placed within the Under Care Unit on evaluating each foster care placement, whether boarding home or institution, to determine whether the child can return home, must remain in long-term foster care, or whether some permanent placement, such as adoption, can be made for him.

There are many ways to approach an evaluation of a program of services to children. The program might be considered from the standpoint of the number of children who have been enabled to remain in their own homes because of the availability of such services. It might be considered in relation to dollars saved by making placements in foster care unnecessary, or from the point of view of the less tangible human resources preserved. Another viewpoint could be the constructive effect of the addition of professional persons to agency staff. From any of these viewpoints, the implications of the Rensselaer County project seem clear.

¹ Rutgers State University, University Extension Division: Cooperative project report: visiting homemaker service training course. New Brunswick, N.J. Revised Dec. 1, 1960.

THE PROBLEMS OF FAMILIES IN THE AFDC PROGRAM

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MRS. SMITH is the 42-year-old mother of 13 children. Born and reared in the Deep South, she migrated to the Detroit area in late adolescence in search of work during World War II. Despite only a fifth-grade education, she readily found employment during this period of labor shortage and continued to work in an unskilled job until after the war ended and she began having children.

Her children range in ages from 3 to 25. The first six were born when Mrs. Smith was married to a man whom she later divorced because of his drinking. A passing flirtation led to the birth of her seventh child. However, the last six children are all the children of the same father. This man, now no longer in the picture, has never contributed more than intermittently to the family's support.

Mrs. Smith receives the maximum allowance given in the Federal-State aid to families with dependent children program (AFDC) of the Michigan State Department of Social Welfare. This grant is supplemented by the general relief and surplus foods programs of the local welfare department. Nevertheless, Mrs. Smith still has a hard time making ends meet. The family lives in an old and crowded tenement building in need of repair, in a neighborhood where there is much crime and delinquency. The children are not always properly clothed or fed, and some of them are badly in need of medical or dental care. Often they do not have enough money for their school supplies and laboratory fees.

Poverty is obviously an omnipresent problem in the Smith family. But poverty in this family, as in many of the 9.3 million families in this country with incomes under \$3,000, is a reflection of a complex of

other problems. Some of these have been noted in a congressional report:

A closer examination of the statistics regarding poverty shows the scars of discrimination, lack of education, and broken homes. Of the poor, 22 percent are nonwhite and nearly one-half of all nonwhites live in poverty. The heads of over 60 percent of all poor families have only a grade school education. . . .¹

While sharing the complex problems of poverty with a host of other families, the Smith family experiences these problems in its own ways, and has its own strengths and weaknesses to help or impede its efforts to break out of the poverty chain. In addition to money, it needs services to tip the balance in favor of the strengths—services based on an understanding of the family's own perceptions of its problems and how these may be overcome, as well as on the perceptions of the experts.

In preparation for the development of a special service program for families in the AFDC program in Detroit, the University of Michigan School of Social Work has undertaken an exploration into the mothers' perceptions of their problems and how well these correspond with the views of the public welfare workers and social scientists. The undertaking is part of a project being carried out in the department by the school, with a Federal grant from the Children's Bureau, to demonstrate the utility of the social group-work method in a public welfare setting.²

This analysis is the responsibility of the authors, and not of the Michigan State Department of Social Welfare or its staff.

In this project, mothers in the AFDC program were invited to form discussion groups, each group to focus on one area, such as the mothers' employment opportunities, the adjustment problems of families with incapacitated fathers, child-rearing difficulties, and school problems. The groups met weekly for 6 to 12 sessions. Leaders, drawn from the agency's personnel and students of the School of Social Work, were closely supervised by an experienced social group worker.

We quickly learned that in order to provide an effective service, we need to know more about the families' problems and their origins—from the viewpoints of clients, workers, and social scientists. The following findings are based on preliminary data gathered during 1963-64 and a review of the literature. More complicated data, gathered in 1965, are now in the process of analysis.

The Clients' View

We constructed an open-end, probe-type questionnaire eliciting information about the immediate problems of applicants for and recipients of AFDC (hereafter called "clients") and their plans for solving them. Included were such questions as "What has worried you most during the past few weeks?" and "What have you been trying to do about this problem?" The questionnaire was administered to 16 applicants to the program after the completion of the regular intake interview. A similar questionnaire was administered during the same period to 17 mothers in the group sessions focused on the mothers' employment problems.

The problems mentioned by mothers in the two samples were similar, except that employment problems, as would be expected, were mentioned more often by those attending the group meetings.

As anticipated, many of the participating women described concrete problems. Fifty-eight percent of the problems mentioned involved the need for money, either in general or for specific purposes such as medical care or school clothes. This percentage included the 16 percent of the problems mentioned which were concerned with the mothers' own employment difficulties or those of their husbands, and the 13 percent that were concerned with poor living quarters or the necessity of living with relatives.

One-quarter of all the problems delineated had to do with children. (Some of these were also included in the 58 percent involving the need for money.) Among the specific difficulties mentioned were dressing children adequately for school, locating a good

babysitter, and the effects on a child of living in a crowded home with quarreling relatives. In addition, a good deal of general anxiety about the children's future was expressed, especially in relation to the lack of a father in the home, the mother's inability to give children the things they needed or wanted, and fear of not being able to rear the children properly.

Somewhat less expected was the degree of concern about health—the focus of 19 percent of the problems mentioned. Many women expressed worry about specific conditions and the out-of-reach cost of needed medical or dental care. Some mentioned their own and their husband's inability to work because of ill health, and some expressed worry about having nobody to care for their children if they became ill. Four of the women said they had a "nervous" condition. Women whose husbands were incapacitated saw problems in the effect of the man's illness upon relationships within the family and in their own ability to accept the role of household head and breadwinner.

Few of the respondents said much about marital problems, possibly because of the shortness of the interviews. In general, when marital problems were mentioned they were expressed as hurt over divorce or desertion, hope for reconciliation (though the husband may have been gone for several years), or unhappiness over the actions of an estranged husband. One woman said flatly that if she could remarry, all her problems would be solved.

While much anxiety was expressed about specific areas of social functioning, almost one-fourth (2 percent) of the problems mentioned indicated the existence of a more or less generalized anxiety about the present or the future. Nevertheless, few respondents indicated having plans for alleviating their problems or any idea where they might get help with them. Even the few who said they had mad plans or knew where they could get help expressed little hope of improvement. It may be that the client's very anxiety about her problems prevent her from doing anything about them. This is a hypothesis presently being tested.

In summary, our inquiry indicated, not unexpectedly, that the mothers involved saw the scarcity of money as their major problem. They apparently felt helpless about the situation they were in and knew of no way to get out of it. They revealed little awareness that a part of their problem might have been their own inability to call on the personal and situational resources at their disposal. How-

er, they did show concern about the effects of their present circumstances on their children.

be Workers' View

Workers' perspectives are colored both by agency policy and the attitudes of the public at large. At times their views reflect the inconsistencies of both these frames of reference, particularly since the emphasis in the program is changing from income maintenance to rehabilitation.

In the study, the opinions of the agency's caseworkers and supervisors were sought in two staff meetings. The lists of problems turned in by the caseworkers, when recommending clients for participation in the social group-work meetings, constituted another source of information.

We found that the caseworker tends to see most early what the client sees least clearly: that in any instances the client's inadequacy in using her resources led to her present problems and are at least partially responsible for her inability to get out of the situation she is in. The caseworkers describe the clients as living from day to day, or even in the last, as if all their ambitions and hopes had ended with the crisis that led to the application for public assistance. Some are described as immature, emotionally unstable, alcoholic, or immoral; some as being pleasure-bent with little or no interest in their children, their homes, or employment. Others are described as tending to give their children excessive protection, but, paradoxically, seeming unaware that responsible behavior in other areas of life may so affect their children. Other problems mentioned were poor budgeting of funds, unwise buying, poor housekeeping, and carelessness in the physical care of children.

At the same time, the caseworkers recognized the fact that most of the women in the program have problems that are unrelated to their morals and values. They also recognized that those women with questionable values have never experienced, and do not now see evidence of, any other kind. They pointed out that many clients in seeking employment are handicapped by real problems, such as inadequate child care facilities, transportation difficulties, poor personal appearance, chronic ill health, and lack of education and skills. They pointed out that, for many clients, employment offers no real economic advantages unless it is steady and secure and the money earned is budgeted for an unmet need rather than deducted from the assistance grant.

The workers expressed particular concern for the

children in the program, most of whom are living in broken homes. They mentioned the lack of appropriate opportunities for male identification for boys in fatherless homes. They expressed somewhat less concern about the psychological effects that divorce, desertion, or illegitimate pregnancy may have upon the mothers themselves or about their difficulties in trying to do a job generally carried out by two persons. However, they did point out that the women in the AFDC program are lonely women who have few social outlets. One caseworker suggested that society may be expecting higher moral standards of these women than are common in the general population. Many others expressed concern not only for the children in the program but also for their mothers, and gave evidence of wanting to help them.

Sociological Factors

From the sociological point of view, a mother who receives public aid is a deviant in several ways. She is a member of the lower class in a society where middle-class values predominate. She is supported by public funds in a society in which self-support is the tradition. Unless she is one of the mothers who is in the program because her husband is incapacitated, she is rearing children without a father present in a society whose acceptance of the broken home is much stronger in print than in actuality. She is apt to be poorly educated and may be of less than average intelligence. With all these strikes against her, she is expected to live on an income which is no more than minimal by any standards and less than minimal by many.

Social scientists point out that one of the strongest determinants of an individual's chances in life is his position in the class structure.³ In a sense, social class defines the individual's responses to the major social pressures. Lacking the partial protection that money, power, or personal influence can give, the child born into a family poor in money, education, and skills is more vulnerable than others to the vicissitudes of life. His chances for getting a good education are poor for several reasons. He receives less than normal encouragement and enrichment in the home; and possibly also less than normal in school, for cultural deprivation may give an appearance of stupidity even to a bright child. In addition, the school system may be dominated by middle-class values to such an extent that neither the content nor methods of the teaching are effective with a child from a different background.^{4, 5}

The poorly educated person finds few employment

opportunities open to him, and these decrease as technological advances eliminate more and more unskilled jobs. Such jobs as are open to him are the least desirable ones in terms of pay; job security; working conditions relevant to health and safety; and fringe benefits, such as insurance and sick leave. Frequent layoffs are likely, and savings to tide the family over a crisis are almost impossible to come by.

Having less access to adequate medical care throughout his life than most people, the person of low socioeconomic status is more prone to illness. Since his employment often requires physical labor, he can become incapacitated by a physical condition that would not be incapacitating to persons in more sedentary work. His poor education and lack of skills make him less adaptable to new occupations after an economic crisis.⁶

The income of the families in the AFDC program is at the lower limits of low incomes. Housing is, of necessity, usually in cheap rental units where the condition of the building may create problems in housekeeping and in efforts to make the home attractive. Drab and deteriorating housing, depressing both adults and children, often discourages women from any effort to improve their homes. Overcrowding in the homes of relatives, not uncommon in families in the AFDC program, not only requires greater physical effort in housekeeping but also creates problems in family relations.

Thus, economic need affects every part of daily life.

Receiving support from public funds is not an unmixed blessing. This is particularly true for the mothers in the AFDC program, a program long the target of much public disapproval. The uniform minimum standards of need limit to employment expenses and a few unbudgeted items of need the amount of any additional income they may receive without having their AFDC payments reduced. Thus, a mother cannot raise her family's economic level above minimal standards unless she is able to take on the entire burden of the family's support.

Psychological Factors

Among the most pervasive effects of social class status are the attitudes and values instilled in children. Not only are differences in opportunity perpetuated in each succeeding generation, but a style of life and a value system commensurate with the realities of the position are also perpetuated. Many studies have shown class differentials in child-rearing practices,⁷ health practices,⁸ living patterns,⁹ and

attitudes toward sex.¹⁰ Current theories of child development indicate that such differences experienced as children will produce psychological differences in adults, differences which tend to maintain adults in the socioeconomic status of their childhood.

Rainwater, Coleman, and Hlandel have studied the attitudes of women of lower socioeconomic status.¹¹ Presumably, the AFDC clients are similar to these women, with two important exceptions: the AFDC recipients must live on an income considerably below that of the women these investigators studied; and most of the women in the AFDC program have gone through marital crises.

The women studied by Rainwater and associates regarded themselves as acted upon rather than acting. They saw the world as unchangeable. Such a woman responds only when she is approached in terms that are "specific, clearly defined, and readily understood". She feels helpless in the face of a chaotic world; she does not reach out to it. Seeing what happens in life as based on luck or fate rather than on her own actions, she has a "fairly pervasive anxiety over possible fundamental deprivations."

Such a woman does not lack hope, for luck may also be good, but she does not expect to be personally successful against forces she cannot control. Her gratifications tend to come from her own limited world of husband and children. She likes to be "needed." Yet, again, she does not see herself as having effective power over her husband, and little over her children after their babyhood. She greatly fears loneliness.¹¹

What then must be the psychological state of the AFDC recipient who, divorced from or deserted by the father of her children, is in the midst of a crisis of the type most feared by women of low socioeconomic status? Surely the sense of a chaotic world of personal inadequacy, and of anxiety over future catastrophe must be increased.

One may assume that the dissolution of a family unit is a traumatic experience whatever the emotional relationship of the adults involved. Regardless of any other emotions, the very fact that the relationship has failed tends to lower the self-esteem of both husband and wife. Social disapproval often complicates the adjustment. A woman who has been deserted or divorced against her will might be expected to have a sharp sense of personal failure and inferiority as well as a good deal of bitterness, which may be turned either outward upon the former spouse or inward upon the self. When the woman has to depend upon public funds for support, the

sense of inadequacy may be aggravated and may in turn heighten the helpless and dependent attitudes fostered by the lifetime experiences encountered by persons of low socioeconomic status.

Mothers As Family Heads

The mother who has become head of the family through divorce, widowhood, or the incapacity of the husband is a focal point for many of the conflicts in the value system of society. Society's expectations of her, as well as her own, are apt to be confused and contradictory. A woman should work to support herself, rather than become dependent, but a mother should stay home and take care of her children. A woman should help her family in any way possible, but her role in marriage should be that of a dependent and relatively subordinate partner. A woman may work so long as her children are well cared for, but society is not obligated to help her arrange for the day care of her children. A woman alone must be strong enough to take over the paternal role of breadwinner and disciplinarian while maintaining her own role as housekeeper and mother; yet she must remain feminine enough to prevent her children from receiving a distorted conception of the feminine role in social relationships.

Women of low socioeconomic status who are heads of families face additional difficulties. Some have many children whose care leaves them little time for a companionable and educational relationship with them. However, such women are apt to look for gratification from their children in present affection rather than in future achievement.

Such women tend to be interested in broad categories of behavior such as "being good" and "being healthy," but to feel helpless about influencing the details of their children's behavior. When there is no father in the home, their tendency to protectiveness, rather than the fostering of development, becomes further exaggerated. Since the home is the source of the woman's satisfaction, the attention once given to the husband may be transferred to the children. The paradox of overprotectiveness and extreme permissiveness often found in the homes of women of low socioeconomic status may be due to the passive attitudes of the mother toward life in general and toward the children's behavior in particular.^{11, 12, 13}

Women of low socioeconomic status are not joiners; the world must come to them. Such tendencies toward isolation intensify the loneliness of the female head of the household. A woman without a

man is a proverbial fifth wheel in many social activities; yet a mother who goes out with a man must be extremely circumspect in her activities, particularly if she is a recipient of public aid, or the suitability of her home may be questioned. Even when the social activity is irreproachable, the problem remains of finding a babysitter she can afford.

In addition, mothers in the AFDC program who are raising their children alone face the same problems confronting any woman in this situation. How can they provide male identification for their children? What priorities must they set upon their time and energies? In short, how does one play two full-time roles concurrently?

The conflicts implicit in the social role of a mother in the AFDC program, and the contradictory and often ambiguous demands society makes upon the woman who is rearing children without a father in the home, are likely to create a paralyzing level of anxiety in the individual. Studies have indicated that persons subject to conflicting forces are likely to react not with "goal directed activity" but rather with "restlessness, a desire to leave the field, aggressive feelings toward himself and others and so on."¹⁴

Such a level of anxiety may become a problem in itself. It may be the source of the tendency to live in the present, and of the pleasure-bent behavior noted by the caseworker in our study. It may prevent clients from making greater use of the resources available to them.

The Practitioner's Problem

The views of the client, the social worker, and the social scientist overlap, although there are differences in emphasis both within and among groups. Nevertheless, all three groups have the same goals for the family in the AFDC program: financial independence and emotional security.

The problem the practitioner faces is to find a way to help the family to achieve these interlocking goals. The clients' complex, interrelated problems cannot be reduced to a simple cause-and-effect formula. All of the major factors seem to be both causes and effects, like "the chicken and the egg." However, the circular cause-effect relationship may well mean that changes accomplished by intervention in one area of life will in turn affect many other areas. Therefore, the practitioner needs an integrated view of the family, adding to his own observations the perspectives of the client and the social scientist.

With these perspectives, he will find that each family requires a somewhat different rehabilitation

plan. He may need to deal with pressing situational factors by helping parents and children secure the clothing, housing, and medical care necessary for maintaining the kind of standard in their daily living under which they can build the self-confidence required to help themselves in other ways. He may need to help parents and children to improve their education and skills by referring them to training or retraining programs or working with school personnel. He may also find need to deal, through referral or directly, with the many psychological factors impeding the family's solution of its problem. Some mothers may require counseling through group-work and casework methods in order to change attitudes and values which are detrimental to themselves or to their children's development. Some may also need help in learning how best to carry out the dual role of mother and family head and in weathering the unusual stresses this entails. Some children may need special help with emotional problems.

This review suggests several foci requiring special attention. One is the problem of psychological passivity, which in so many families in the AFDC program not only inhibits efforts toward solving immediate problems, but also affects the quality of parental control over children and the quality of the self-image internalized by the children. Another is the need for helping families develop techniques of living in a manner acceptable to society and advantageous to the physical health and well-being of the family, techniques their past experiences have not given them an opportunity to develop. A third is the need for defining the appropriate role for lone parents and for recognizing the structural limitations as well as the psychological elements in the one-parent family.

Effective intervention at the individual or family level requires a framework of appropriate public social policy. It must be adequate to the need and involve a strategy that takes account of the complexity of the problem. Whatever the nature of the problem it attacks—sociological, psychological, or social-psychological—the problem areas are so interrelated that intervention in any one can affect the others if it is planned from an all-encompassing perspective.

The important thing is to build on the family's strengths, for, with the help of appropriate community resources, many families in the AFDC pro-

gram have succeeded in improving their situation. For example, let's take another look at the Smith family:

Mrs. Smith gives her children the best physical care possible in her circumstances. Her oldest son is a college graduate and her two older daughters are presently in college. The family is closely knit. When told that he was not obligated to help his half-brothers and sisters, the oldest son said that he paid no attention to that: "They are my brothers and sisters and I will help them as much as I can."

Mrs. Smith has been a member of one of our mothers' groups focused on helping parents maximize the school experience for their children. She has contributed generously to the formation of more useful attitudes on the part of other group members while receiving a good deal of support for her own efforts.

¹ House of Representatives, Committee on Education and Labor Poverty in the United States. 88th Cong., 2d sess. Washington, D.C. April 1964.

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DAY CARE AS A SERVICE FOR ALL WHO NEED IT

KATHRYN CLOSE

A SENSE of urgency and a sense of hope permeated the meetings of the National Conference on Day Care Services, in Washington, D.C., May 13-15. Held under the auspices of the National Committee for the Day Care of Children, the Child Welfare League of America, and the Children's Bureau, the conference brought together more than 1,100 persons to discuss ways of stimulating appropriate day-care services for all children needing them. Its participants included administrators, board members, proprietors and consumers of day-care services, representatives of business and organized labor, and members of a variety of professional disciplines in the health, welfare, and educational fields.

They met in plenary sessions, general sessions of 3 subconference groups, and 24 work groups which on one day focused on specific topics and, on the next, on the problems of States, according to region, and of cities, according to size.

The sense of urgency came from the concern which prompted the conference—a realization that when children have unmet needs, time wasted before filling them can never be made up. The sense of hope derived from the repeatedly expressed feeling that the climate of the day was a fertile one for planting seeds of action.

"You are here at exactly the right moment," the conferees were told by the Vice President of the United States, Hubert H. Humphrey, and he suggested that they "join in the clamor" for the attention of Congress.

"The greatest deficit in America is not the fiscal deficit, but the human deficit," the Vice President said. Naming "the cost of crime, the cost of delinquency, the cost of hopelessness" as "the costs America ought to be concerned about," he suggested "spending a little extra" in programs that yield dividends—improved education, cultural activities, wholesome recreation, and public day-care centers.

Calling day care a "national necessity," particularly for children of working mothers, the Vice President pointed out that 86 percent of such mothers are working out of economic necessity—"the complaints against them come from somebody who doesn't have to work and doesn't understand the circumstances." But he also spoke of the need for day care for physically, mentally, or emotionally handicapped children, and particularly for children from poverty-stricken homes. "Day care is not a limited concept; it is not just for low-income families and working mothers. It is for the child who needs it, when and where he needs it, and for the length of time he needs it."

This was the concept of day care stressed throughout the conference. It was spelled out in the opening address by U.S. Commissioner of Welfare Ellen Winston as "the right of the child for adequate day-care services as a way of strengthening and preserving family life." And it was illustrated at the same banquet session by six consumers of day-care service—five mothers and a father who told what the service meant to them.

"I'm sure the strain on me was a strain on my children," said a young doctor's wife, mother of two hyper-active retarded children. She told of improvement in the children's behavior as well as her own sense of well-being since she placed them in a day-care center.

"I can now work in peace," said a mother of six children, who had turned to a day care service in the housing project where she lived when her own mother, the children's previous caretaker, died.

Another mother of six said she lived on an isolated farm in the Kentucky mountains, far from other families and children. She gave a mission-housed day-care center the credit for the fact that her fifth child, now in school, "has outdone the four who went before him."

The Need

A spectrum of problems leads to the need for a spectrum of services in day care. Katherine B. Oettinger, Chief of the Children's Bureau, pointed out in another session, identifying some as "family breakup, changing family structures, unwed mothers, physical handicaps, mental retardation, emotional problems and mental illness, job mobility, cultural deprivation." And these, she said, are not limited to any one income group; nor are haphazard arrangements for the care of children in the mother's absence. Day-care service, she maintained, is more than "a holding action," for it provides the "social and emotional enrichment" that many children need.

Testimony to the inadequacy of day care today came throughout the conference. It was backed up by some stark figures. Speaking of the "attrition" in such services since the Lanham Act expired at the end of World War II, Mary Dublin Keyserling, Director of the Women's Bureau, U.S. Department of Labor, pointed out that while 5½ million more women are working today than at the peak of the war, "the licensed public and voluntary day-care facilities now available to our children provide for only about one-sixth of the number cared for as of July 1945." Chicago, she said, had 23 publicly supported day-care centers at that time and now has only one. Detroit, with 80 then, has none. Mrs. Keyserling predicted a 17-percent increase in the employment of women by 1970.

What this may mean to children was illustrated by some figures presented by Mrs. Oettinger from the preliminary findings of a survey made in February 1965 for the Children's Bureau and the Women's Bureau by the U.S. Bureau of the Census. (See p. 159.) Nearly a million children under 14 were estimated to be on their own during working hours, she reported.

What one speaker called "schizophrenic cultural attitudes" took the onus for the lag between need and services—the deeply ingrained feeling that mothers should stay at home with their children (unless they are threatened with public dependency) in a culture which depends on women workers for much of its prosperity. Joseph H. Reid, executive director of the Child Welfare League of America, told of findings of a study of attitudes made by the League which showed that many of the same people who said they did not believe in day-care services for children also disapproved of requiring standards for those day-care services which do exist.

Coordination

But Mr. Reid also suggested that research into the attitudes and standards of the professional people who are engaged in day care might reveal that differences of opinion among them about "what it is, who should be doing it, and what it should be composed of" constitute one of the chief barriers to advance.

Indirect evidence of such "administrative barriers" was provided in the

frequent calls for coordination heard from the platform and in discussion groups—coordination in planning, in financing, in interpretation, and in the provision of services. These were directed not only to the fund-providing and standard-setting Federal and State agencies, but also to the professions which provide the health, education, and welfare components of day-care services and nursery schools. There was an obvious consensus that both types of services should be strong in all three components. As Julius B. Richmond, M.D., program director of the Office of Economic Opportunity's Project Head Start, expressed it, "the needs of the young child must be met comprehensively in order for him to thrive." He proposed the term "child development center" to place the emphasis on the child—"and by inference his family"—rather than on the institution.

The Family

The family-centered focus of day-care service and its nature as a supplement to family life were stressed again and again. Conference told of "reaching out" to involve reluctant parents in day-care programs as learners, as observers, and even as participants. One said: "Our greatest gratification is when a child, becoming more relaxed and giving under our care, influences his parents, and they become more relaxed and giving." Another told of drawing unemployed fathers into the program's activities: "It gives them a sense of usefulness and they *are* interested in their children."

Repeated warnings were given, however, against expecting a day-care service to accomplish miracles in a social vacuum. In describing the deteriorating influence of poverty and discrimination on "millions of American families," James R. Dumpson, New York City Commissioner of Welfare, made it clear that more than day care is required for those whose lives are marked by "poor quality education, overcrowded dilapidated housing, poverty, poor physical and mental health, alienation from the larger community, humiliation and rejection based on ethnic considerations."

Between 5 and 6 million children live in one-parent families, Mr. Dumpson said, and Mrs. Keyserling pointed out

that in 56 percent of the fatherless families in this country the mother is working, including 37 percent of those with children under 3. Supplementing family life for these children, a number of participants suggested, would mean drawing "male figures" into day-care programs as volunteers or staff assistants.

Manpower and Staff

Project Head Start received much attention at the conference—both as an opportunity and a threat. The Vice President referred to it as an "unprecedented assault on the deprivation of youth"—one "going so fast that the critics can't catch up with it"—a pace confirmed by Dr. Richmond's announcement that it would soon make grants to about 2,600 communities for over 10,000 preschool programs involving about a half million children. Nobody denied the opportunity this represented for children, but many a worry was expressed by directors of established services as to what this would mean in competition for qualified staff, especially preschool teachers. "We can't pay the salaries to compete," was a frequent comment, or "We already lose most of our teachers to the public school system as soon as they become certified." One participant remarked that the best way to get salaries up was through such competition.

Expansion of day-care services—the purpose of the conference—would depend on ingenuity in recruiting, training, and use of staff, it was generally agreed. "We must all be willing to change some of our preconceived ideas about *how* we train people," said John Neimayer, president of the Bank Street College of Education. He suggested more training on the job, more intensive short-term courses, the provision of good supervision, and changing the traditional qualifications for trainees. Francis Keppel, U.S. Commissioner of Education, also proposed seeking new resources of teaching, citing an example of a day-care center in Oakland, Calif., where children received educational help from older students, mothers volunteering their time, and caseworkers assigned to the center.

Others saw nonprofessionals, whether paid or volunteer, as fitting almost anywhere in the program, but always under supervision. They saw sources of help in grandparents, teenagers, VISTA

unteers, neighborhood mothers, and even "the old man who likes to whit—" High school graduates might be attracted to the program, it was suggested, if educational opportunities leading to careers were made available. They might be recruited, it was further suggested, if family life education courses used day-care centers as field placements.

Innovation and Protection

Innovation and a reexamination of principles to open long-stuck doors to children's opportunity were strong underlying themes of the conference, especially in relation to children for whom day-care services are all but lacking—infants and toddlers, school-age children, children of migrants and of military personnel, and handicapped children.

One work group spent some time discussing how many adults to a child a group care service for infants should contain—a type of service once regarded as unthinkable by standard-setting agencies. And, pointing out that the Children's Bureau is seeking solutions for the vast number of inadequately cared for children among the 1/2 million children under 3 whose mothers are working, Mrs. Oettinger reported that the Bureau had modified its previous position of discouraging group care for such young children and was financing two research projects to determine effective ways to provide this kind of service.

But family day care was obviously still the method preferred by child welfare agencies for children under 3. The question was raised, however, as to whether this could expand enough to meet the need.

Family day care was also discussed as a possibility for school-age children—"by the time school is over the child may be tired of a group"—but after-school group programs, with emphasis on recreation, received the most attention. Both space and lack of community interest were mentioned as major problems in establishing services for this "forgotten day-care responsibility." Schoolhouses and grounds were identified as widespread, accessible, and, except in school hours, largely unused resources. Labeling such locked-up schools as "fortress schools," Dr. Keppel recommended replacing them "not with bricks and

CHILD CARE ARRANGEMENTS OF WORKING MOTHERS

About 1 million children under 14 years of age whose mothers were employed in 1964—including 38,000 children under 6—were expected to care for themselves while their mothers were at work. These children represented 8 percent of the 12.3 million children under 14 whose mothers worked either full time or part time for 27 weeks or more in 1964. Approximately 6.1 million mothers of at least one child under 14 were so employed. Of their children, 3.8 million were under 6 years of age, of whom 1.6 million were under 3.

These are some of the preliminary findings of a survey sponsored by the Children's Bureau and the U.S. Department of Labor, Women's Bureau, and carried out in February 1965 by the Bureau of the Census, using its national sample of households. Besides a total lack of arrangements for 8 percent of the children, the survey revealed a variety of child care arrangements:

- Forty-six percent of the children were cared for in their own homes, by a father (15 percent), another relative (21 percent, including 5 per-

cent by a relative under 16 years of age), or by a nonrelative (10 percent).

- Thirteen percent were looked after by their mothers while at work.

- Two percent were cared for in group care, such as day-care centers or after-school centers. 1 percent of the children under 3 years of age, 7 percent of those 3 to 5 years old, and 1 percent of those 6 to 11.

The mothers of 15 percent of the children worked only while the children were in school.

Data on income revealed that the children lived in families with a wide range of income, an almost equal number—2 million—belonging to families having under \$3,000 a year and to families having over \$10,000 a year.

The preliminary findings of the survey were released by the two sponsoring Bureaus in mid-May in a publication, "Child Care Arrangements of the Nation's Working Mothers, 1965: A Preliminary Report," prepared for the National Conference on Day Care Services. A final report will be issued after all data have been received from the Bureau of the Census.

lement but with a new focus and a new spirit."

Group day care for children with handicaps—physical, mental, or emotional—was stressed as a grave need, not only for the sake of the social and cognitive development of the children, but also to relieve the strain on their heavily burdened mothers. Special day-care services—now rare—were called for as essential for the severely handicapped. At the same time, operators of regular day-care services were urged to open their doors to the less severely handicapped and to prepare their staff and facilities for their special needs. Parent counseling and flexible arrangements with community services were noted as especially important in services for the handicapped.

The culturally deprived child, noted as a special risk in regard to emotional, social, and cognitive development, was

the target of the conferees' strong educational emphasis. Two speakers, Milton J. E. Senn, M.D., and Robert D. Hess, referred to recent research showing that the basic difficulty of children who fail in school is a deficit in language development. Dr. Senn said that this research—coupled with new knowledge about the preschool child's readiness, even in infancy, to absorb the skills prerequisite for learning to read, write, and compute—underscored the importance of the educational component in day-care centers. Dr. Hess, however, warned against putting too much faith in experience enrichment and stimulation as such, and told of research which indicates that what the child with a language deficit needs is not merely to learn "new words" but to be shown "how ideas and events are related to one another."

Two work groups called for the wavy-

ing of State residence laws which prevent children from receiving services, especially children of migrant agricultural workers and children of military personnel. The waiving of State laws prohibiting the group care of migrant children under 3 was also urged.

Side by side with the conference's accent on innovation was a strong recognition of the importance of standards and of licensing in upholding and improving the quality of day-care service, whether offered on a commercial or a nonprofit basis. Standards were defined as the "ideal" in day care, and licensing as a way of working toward this and so protecting "children, their parents, the operators of services, and the community." "Standards always have to be a little out of reach," said one operator, "so we will have something to work toward."

"Double standards" in licensing were especially decried as confusing and unfair, and by this term was meant both the exemption of services under public and religious auspices and the differences in standards required of preschool services designated as "welfare" and those designated as "education." Correction, it was recognized, would involve change in State laws.

Much misunderstanding of standards could be eliminated, it was suggested, if operators and other community representatives were involved in their development. Flexibility in the use of authority was suggested as a means of using licensing as a method for bringing about improvement; but one participant—a licensed operator—saw "too much flexibility" as holding the danger of weakening strong laws.

Finances and Politics

Where and how to get funds? This double-headed question, holding the key to both expansion and improvement in day-care services, ran like a strong cord throughout the conference.

The answers to *where* leaned heavily on the Federal Government, with State and local resources—public and voluntary—recognized in a somewhat less hopeful way.

Present sources of Federal funds were pictured as promising "seed money," but confusing in their variety and differences in requirement. For example, money obtained through Project Head Start or the community action programs

of the Office of Economic Opportunity could be secured with as little as 10 percent "matching" funds from State or local sources, while funds obtained through the Children's Bureau, extremely limited in the first place, after January 1, 1966, could be had only through a real 50-50 matching from the State. Recommendations for eliminating this matching requirement were many; and the conferees applauded loudly when Senator Abraham A. Ribicoff of Connecticut announced that a "child care package" which he plans to introduce to the Social Security Amendments of 1965 would do away with this matching requirement, raise the total of child welfare funds authorized, and require each State child welfare services plan to include day care by 1967.

A promise for eliminating some of the administrative confusions in the Federal day-care and preschool education picture came when Mrs. Oettinger told of a Children's Bureau plan to convene a small group, representative of Federal agencies interested in day care and early child development, to prepare a statement to serve as a "united base and common language" from which these agencies might operate.

The answers to the *how* part of the where-and-how question were many, but added up to two related forms of action: community mobilization and political action.

Here again, a "united front" was suggested, especially in localities where voluntary agencies reportedly have a hard time persuading United Funds of the importance of adequate salaries in upholding the quality of day care; and where unconvincing city councilmen and State legislators may impede the flow of any public money into the program. Leo Perlis, director of the AFL-CIO Community Service Activities, and W. O. Heinze, president of the International Latex Corporation, both spoke of the importance of involving business and labor in fund raising and planning because of their stake in seeing that good day-care services are available. Day-care councils were proposed to plan, to interpret, to lobby.

Strong plugs for lobbying on the national level were put in by Vice President Humphrey—"The Congress are here to listen to you. . . . Go up to Capitol Hill and lobby your heads off"—

and by Senator Ribicoff, who departed from his prepared speech to give the conferees a practical lesson in how to approach a Senator or Congressman. Said the Senator: "Next time you come to Washington, send a letter ahead to your Senators and your Congressmen. Sit down and talk to them face to face when you get here, and then you will really have a chance to influence legislation."

Back to Work

In summarizing the subject work groups at the final session of the conference, Mrs. Randolph Guggenheim brought out their stress on coordination: the need for increased Federal funds; parent participation; community interpretation; better salaries; inservice and professional training; broadened representation on agency boards; the use of volunteers and other types of auxiliary personnel; and the formation of day-care councils or local affiliates of the National Committee for the Day Care of Children.

Leonard Mayo, president of the International Union for Child Welfare and chairman of the conference, summarized the State- and city-focused work groups, bringing out their requests—

- to the Federal Government for more clarification of policies; more detailed guidelines and consultation on standards and service operations, including up-to-date cost analysis figures; funds for construction of facilities; an open-end appropriation for child welfare;

- to the States for area meetings to review State standards and legislation; the strengthening of State advisory committees through broadened representation; review and strengthening of State licensing laws;

- to localities for having the purchase of day care by public agencies on actual costs; and establishing central recruiting and training programs for day-care personnel.

Then Mr. Mayo turned to the question of *how*, and he too put a heavy accent on political know-how and action. After giving a seven-point "Mayo's law" for approaching councilmen, State legislators, and Congressmen, he said:

"We can go to work with the knowledge that no other country in the world has a political setup so responsive to what people want."

BOOK NOTES

THE CASE FOR THE WORKING MOTHER. Dorothy Whyte Cotton. Stein & Day, New York. 1965. 185 pp. \$4.95.

In this book, the new editor-in-chief of *Parents' Magazine* examines the case for (and also against) the working mother, from the standpoints of how mothers can handle this dual responsibility; the effect on husband, children, other relatives, neighbors; the problems of babysitters, mother substitutes, nursery schools, day-care centers, after-school facilities; and how to get back into the labor market.

Pointing out that one out of every three mothers who have children under 8 are holding paying jobs, the author maintains that there is a need for society to come to grips with the "quiet evolution" in the employment of mothers outside the home. She cites numerous "case histories" of working mothers—not all of them successes—and gives special attention to ways to insure proper care of children of various ages during the periods when their mothers are absent from the home.

CHILD HEALTH: Its Origins and Promotion. Edited by F. W. Clements and B. P. McCloskey. Edward Arnold, Ltd., London. (U.S. agents: Williams & Wilkins, Baltimore.) 1964. 402 pp. \$5.75.

Originally conceived as a tool for imparting knowledge about child health to Australian teachers in training, this book, written by representatives from the fields of medicine, public health, and psychology—most of them Australians—is also recommended by the authors for students of nursing, medicine, and social work. Its emphasis is health as a positive state rather than the antithesis of illness. The editors are, respectively, Senior Lecturer, Child Health, University of Sydney, and Assistant Chief Health Officer (Child Health), Department of Health, Melbourne.

The collection is divided into the following five categories: "Human Change and Stability;" "Normal Growth and

Development in a Western Society;" "Health and Well-Being;" "The Child and Disease;" and "Education for Health."

DIRECTORY FOR EXCEPTIONAL CHILDREN. Compiled and published by Porter Sargent, 11 Beacon Street, Boston, Mass. Fifth edition. 1965. 702 pp. \$7.

Included in the more than 3,000 U.S. facilities—schools, hospitals, clinics, and others—for physically, mentally, or emotionally handicapped children described in this fifth edition of a directory first published in 1954 are 136 new programs and 300 programs, not previously listed, offering help for youth. About 100 facilities are noted as having closed or merged with other programs since 1958.

The new edition reveals a continuance of the trend toward nonresident day programs for exceptional children. Day schools and clinics now comprise two-thirds of the Nation's facilities for crippled children; 6 times more day centers than resident facilities have been established for physically handicapped youth since 1953; and, of the 136 new programs described in the book, nearly 50 are day offerings for mentally retarded children.

The directory reveals a 25-percent increase of programs of vocational training. More than 130 of the facilities described offer vocational training (apart from occupational therapy given by many more); 30 of these have been established since publication of the last edition of the directory in 1962.

MOTHERS OF SIX CULTURES: antecedents of child rearing. L. Minturn and W. W. Lambert. John Wiley & Sons, New York. 1964. 351 pp. \$7.25.

Using interview techniques and the statistical method of factor analysis, the research reported in this book identifies factors or dimensions by which differences and similarities in child-rearing practices may be described among mothers who live in such diverse cultural settings as India, Oki-

nawa, Mexico, Kenya, the Philippines, and the United States. Among the dimensions of child rearing found by statistical analysis were those dealing with maternal responsibility for the child, maternal warmth, and style of reaction against childhood aggression. A considerable part of the book is devoted to describing the child-rearing practices of mothers of each of the six cultures.

This study differs from most investigations of child-rearing practices in that its emphasis, instead of focusing on the effects of child-rearing practices on subsequent behavior of the child, is concerned with the antecedent conditions existing in the social and economic structure which may influence the pattern of the mother's child-rearing practices. For example, mothers living in a culture in which they are expected to participate in the economic maintenance of a family are likely to impose greater responsibility requirements on their children than mothers in a culture requiring little participation of this type from mothers.

VISION OF CHILDREN: an optometric symposium. Edited by Monroe J. Hirsch and Ralph E. Wick. Chilton Books, Philadelphia, Pa. 1963. 431 pp. \$17.50.

The contributions to this symposium represent a wide range of subjects related to children's vision. Visual aspects of growth and development are discussed, with emphasis on prevention of visual disability. The contributors are almost all practicing and teaching optometrists.

Chapters with a large volume of theoretical and practical technical information, not assembled elsewhere, include: Weymouth's "Visual Acuity," Hirsch's "Refraction of Children," Morgan's "Anomalies of Binocular Vision," and Heath's "Color Vision."

Several chapters, with a more limited appeal, deal with practical aspects of clinical management, while other chapters are directed to the optometrist in the role of parent's adviser.

Summaries of ocular pathology and special educational considerations for the visually handicapped child are also included.

The demographic considerations that stimulate optometry to concern itself with children are discussed in Hofstetter's introductory chapter "Optometry and Children's Vision."

HERE AND THERE

Education Act

On April 11, 1965, the President signed the Elementary and Secondary Education Act of 1965, "to strengthen and improve educational quality and educational opportunities in the Nation's elementary and secondary schools."

The act's five substantive titles authorize the channeling through the Commissioner of Education of approximately \$1.3 billion in Federal funds into education in this country.

Title I provides for a 3-year program of grants through State departments of education to local school districts containing concentrations of children from low-income families. The money is to be used for programs and projects (including the acquisition of equipment and construction of facilities) designed to meet the special needs of disadvantaged children. Arrangements such as educational television and radio, mobile educational equipment, and "dual enrollment" (permitting children in private schools to take courses in public schools) must be made to include the disadvantaged children attending nonpublic schools.

The grants to the States under Title I are to be based on a formula which takes into account average annual per-pupil expenditure and number of school-age children from "low-income families"—defined for 1966 as families with incomes under \$2,000 per year or receiving more than \$2,000 from the program of aid to families with dependent children. The Office of Education, U.S. Department of Health, Education, and Welfare, has estimated that this could amount to \$1.06 billion for the fiscal year 1966.

Title II, carrying a specific authorization of \$100 million for fiscal 1966, provides for a 5-year program of grants to State departments of education to make available, to children and teachers of both public and nonpublic schools, library resources, textbooks, and other published instructional material, the title to which would remain

vested in a public agency. The States are required to develop policies to assure that the Federal funds are not used to supplant money that in their absence would be used to purchase such materials.

Title III, with a \$100 million authorization for fiscal year 1966, establishes a 5-year program of grants to the States for supplementary educational centers and services to enrich the programs of elementary and secondary schools. Among other activities and services specifically mentioned are: special instruction in science, languages, music, and the arts; vocational guidance and counseling services; health and social services; remedial instruction; special programs during periods schools are not regularly in session; services for isolated rural areas; and the employment of specially qualified personnel, including artists and musicians.

Title IV extends the cooperative research program under which the Commissioner of Education makes direct grants for educational research and adds provisions for training research personnel and the construction and operation of research facilities. An appropriation of \$45 million is being requested for research and training for fiscal 1966; for construction, a total of \$100 million over a 5-year period.

Title V, with a \$25 million authorization for 1966, initiates a 5-year program to stimulate and assist in strengthening the leadership resources of State educational agencies.

Mental Retardation

A possible link between mental retardation and toxoplasmosis has been reported by a team whose research, in the United States and San Salvador, is being carried on cooperatively by the Stanford (Calif.) University School of Medicine and the Palo Alto (Calif.) Medical Research Foundation. Toxoplasmosis, an infectious disease usually passed into the fetus by the mother, is

frequently unrecognized clinically because many infants afflicted with it look normal at birth. Only 1 of 1,000 babies born in the United States have recognizable symptoms of toxoplasmosis, the team found, the total number of babies born with the disease being unknown.

Dr. Jack S. Remington summarized the team's findings at the First Annual Colloquium of the Lt. Joseph P. Kennedy, Jr., Laboratories for Molecular Medicine at Stanford last April. Babies born with the disease, he said, may become mentally retarded within the first 3 to 4 years of life. It is not known how an infected mother passes the organism to the child.

Dr. Remington said the evidence that the infection may be related to mental retardation was gathered in study recently made at the Sonoma (Calif.) State Hospital. Blood tests performed on 350 children whose records showed their retardation to be of unknown origin produced evidence of significant amounts of toxoplasma antibodies in 11 percent of the children. Tests on another 400 children selected after their cases had been studied to rule out toxoplasma infection as a cause of their retardation showed only 3 percent to be positive. A serologic survey conducted in Palo Alto showed that, among 600 women of childbearing age, 29 percent had the toxoplasma parasite. Similar tests conducted in San Salvador proved positive for 60 percent of the women in the same age group.

Volunteers

In the 3 years since the establishment of a volunteer service program in the Children's Division of the Cook County (Ill.) Department of Public Affairs, volunteers have rendered 3,021 hours direct or indirect service to the 4,500 foster children under the legal guardianship of the department. Initiated in December 1962 with a grant from the Chicago Community Trust, the program at present includes 60 volunteers on active status and 51 on a list of prospective volunteers.

The volunteers work as assistants in home finding, child welfare aides, clerical aides, education aides, special program aides, and vocational tour escorts. The home-finding assistants handle telephone inquiries, do a preliminary screening of foster parent applican-

mail recruitment literature, assist in group meetings for applicants, help to maintain inventories of foster homes, and keep the license renewal roster current. The child welfare aides help caseworkers in placing children; visit foster homes to complete questionnaires; and escort children to clinics and on shopping trips. Clerical aides furnish stenographic and secretarial services, gather data for research reports, and assist in manning the division's reception desk. Educational aides tutor children who are in foster care. Special program aides take children to ball games, the theater and the circus, and help in the camp program. Vocational tour escorts take teenagers on career tours to industrial establishments.

Working under the supervision of a full-time professional person, the volunteers serve either 1 day a week or a minimum of 8 hours a month for at least 6 months. All volunteers are required to complete a 2-day orientation course focused on the department's services. In addition, they receive inservice training on their specific job assignments.

A project to use teenagers as volunteers in services for children in the summer months, undertaken by the Division of Family and Child Welfare, Westchester County (N.Y.) Department of Public Welfare, proved so successful in the summer of 1964 that the agency is again carrying out a similar project in the summer of 1965.

Of the 30 young people who applied last summer, as a result of newspaper ads, 37 actually became volunteers and, of these, 31 carried out their assignments for the entire 12 weeks of the project. Except for a few who preferred, or were deemed more suited to, clerical assignments, the young people provided direct service to a total of 30 children—between the ages of 6 and 12—23 of them children in the child welfare services program and 7 in the public assistance program. Five of the six volunteers who did not continue through the 12 weeks were in clerical assignments.

All 30 applicants were screened in 5-minute interviews with the supervising caseworker in which their motives for volunteering were examined, their impressions of what children from different backgrounds would be like explored, and their reactions to the re-

sponsibilities that would be expected of them and indications of their own personal stability observed.

Orientation consisted of two group meetings with the supervisor of the project, at which the needs of the children selected for service were explained and the importance of confidentiality discussed. At a third meeting, held at the halfway point in the project, the volunteers discussed their experiences with children. All but one of the children had been responsive to his volunteer.

The volunteers were under the supervision of a professional caseworker assigned on a full-time basis to the teenage project. Each prepared a written report on his experiences with the child assigned to him. Activities included trips to amusement parks, to the city, to the zoo; helping a child take out library cards; reading, storytelling, and visiting with a child; going for walks and window shopping. The children selected by the agency to receive the volunteers' services were in the main shy children, children from large families, and physically handicapped children. Aggressive children were not included in the project.

The majority of the volunteers came from middle or upper middle class families. Two, however, were in the public welfare caseload, one as a foster child and the other in the AFDC program.

Against Delinquency

Five former leaders of San Francisco street gangs are to be employed and given on-the-job training in a San Francisco juvenile delinquency control program which is part of a demonstration project supported by a Federal grant of \$15,648 made through the Office of Juvenile Delinquency and Youth Development. The project is being carried out by the Institute for Social Science Research of San Francisco State College.

The ex-gang leaders, as detached workers for the Youth for Service Agency in San Francisco, will establish contact with street gangs and work with them informally in their own hangouts. The institute is proceeding on the theory that these ex-gang leaders have insights into youth problems, and rapport with youth, which the presently employed professionals do not have, and that their experiences as youth workers can be used to develop improved mate-

rials for training other youth workers.

Other grants for short-term demonstration projects approved since the first of the year under the Juvenile Delinquency and Youth Offenses Control Act of 1961 include:

- \$52,276 to the Salt River Pima-Maricopa Community Council, Scottsdale, Ariz., to establish a community-sponsored and community-staffed youth center for delinquent boys and their parents on the Salt River Indian Reservation. The center, which will be administered by the tribal council, will also provide services to nondelinquent boys.

- \$67,040 to the Oregon State Board of Control (MacLaren School for Boys), Salem, Oreg., to establish a combined halfway house, vocational training program, and job placement program for "nonschool oriented" boys being returned to the community from a State training school for delinquents.

- \$125,290 to the Welfare Federation of Newark, N.J., to establish a short-term, educationally based, group-rehabilitation program for 14- and 15-year-old boys presenting both behavior and scholastic problems.

- \$99,551 to the Kentucky Child Welfare Research Foundation, Inc., Frankfort, Ky., to help a junior-high-school-based, community-operated center in Louisville to operate a remedial program for "hard-core 13 $\frac{1}{2}$ - to 15 $\frac{1}{2}$ -year-old male offenders" combining work, education, and casework therapy.

- \$34,656 to the Institute for Behavioral Research, Inc., Silver Spring, Md., for a project called CASE (Contingencies Applicable to Special Education) which will develop "new groupings" of subject matter and schedules and reinforcement techniques designed to increase the educational performances of selected boys from the National Training School for Boys, Washington, D.C. This project will be carried through with the cooperation of the Federal Bureau of Prisons.

Accidents

In 1964, accidents, the Nation's leading killer of youth, caused approximately 104,000 deaths—an increase of 3,000 over 1963—according to estimates of the Division of Accident Prevention, U.S. Public Health Service. The Division estimates that about 50 million persons in the United States yearly suffer accidental injuries which either restrict normal activity for a day or more, or

require medical attention, costing the Nation an estimated annual \$15 billion.

Of the two broad categories on which the accidental death estimate is based, "motor vehicle" and "nonmotor vehicle," all of the increase was within the motor vehicle category. Motor vehicle accidental deaths reached a new high of 48,000 in 1964, 5,000 higher than in 1963.

In 1963, the latest year for which age-specific figures are available, the leading causes of accidental deaths among children were: children under 1 (total deaths, 3,500), mechanical suffocation, ingestion of food or foreign objects, and motor vehicles; age 1 to 4 (total 5,100), motor vehicles, fire, and drowning; age 5 to 14 (total 7,000), motor vehicles, drowning, and fires; and age 15 to 24 (total 15,900), motor vehicles, drowning, and firearms. In the 15- to 24-age bracket, accidents cause more deaths than all other causes combined.

Evidence of an urgent need for establishment of master regional poison control centers, to improve the work and services performed by the Nation's 540 poison control centers, has prompted the Public Health Service to initiate a 1-year research project to study the feasibility of the area poison control concept. The project will be carried out by the Metropolitan Denver Research Foundation, Inc., research arm of the Denver General Hospital. The PHS's Division of Accident Prevention plans to establish such centers in several regions of the country. According to information reported to the Division, approximately 500,000 children in the United States annually ingest poisons in liquid or solid form, and some 2,000 persons in all age groups die annually from such ingestion.

Child Welfare Research

Awards amounting to \$404,021 were announced in mid-April by the Children's Bureau for 10 special studies to be undertaken, or continued, under the child welfare research and demonstration grants program.

Three of the grants, totaling \$164,560 were for new research projects in child welfare:

- \$72,762 to the Yale University Child Study Center, New Haven, Conn., for a program to study the differences in the developmental process in children from infancy to age 7 in three settings: group residences, foster fam-

ilies, and the children's own homes. The study will focus on the characteristics of the children's development and the relation of the setting to the children's developmental and behavior problems and to the processes of the children's adaptation to their physical, social, and psychological environment.

- \$50,000 to the Council on Social Work Education, New York City, to develop curricula in social work education related to the welfare of children and the services required by them. Primary goals of this project are the identification of the knowledge required by all professional social workers about the needs of children and the services to provide for them, and the determination of specific additional knowledge and skills required by graduates of schools of social work entering the field of child welfare.

- \$41,798 to Pacific Oaks College, Pasadena, Calif., for an observational study of day-care programs. This study's goal is to find out how the development of children is affected by different types of group day-care programs.

Seven continuing research and demonstration grants in child welfare were awarded, totaling \$239,461: four of them (\$103,789) for research projects and three (\$135,672) for demonstration projects.

Child Development

Differences in the effects of certain types of maternal and child behavior on the intellectual development of boys and of girls are indicated in a recently completed analysis of data from the Berkeley Growth Study, a longitudinal study conducted by the Institute of Child Development, University of California at Berkeley, of children born in 1928 and 1929 as healthy newborns.

The analysis was carried out by two of the study's investigators, who are now with the National Institutes of Health. It revealed changing relationships between types of maternal and child behavior and children's intelligence over the 18-year span of the study, with shifts occurring with the children's changing age but differing according to sex.

For example, the sons of hostile mothers scored high in intelligence in the first year or so, but had low IQ's from 4 through 18. The sons of loving mothers were highly intelligent—grow-

ing from happy, inactive, and slow babies into friendly, intellectually alert boys and well-adjusted, extraverted adolescents. Daughters of loving, controlling mothers were happy, responsive babies who earned high mental scores. However, after 3 years the girls' intelligence scores showed little relation to either maternal or child behavior variables. Their childhood IQ's correlated primarily with the education of the parents and estimates of the mother's IQ.

These differences, with other findings on sex differences, led to a hypothesis of genetic sex differences. The impact of the environment (maternal behavior) on infant boys appeared to be persistent, both their behavior pattern and their intellectual functioning tending to become fixed by the 3d year and to persist at least through their 18th year; while girls' intellectual functioning appeared to be more genetically determined, as though the girls continually readjust their behavior to changing environmental conditions. The girls' intelligence seemed to be independent of those aspects of maternal and child behavior which were evidently important for the boys.

The report of the analysis, "Correlations of Maternal and Child Behavior with the Development of Mental Abilities: Data from the Berkeley Growth Study," has been issued as volume 2 number 6, of *Monographs*, published by the Society for Research in Child Development.

Miscellaneous

"Breakthrough," a new recruitment play on public welfare social work careers, designed to interest high school and college students, had its premier performance on May 25 at the annual forum of the National Conference of Social Welfare, Atlantic City, N.J. It was produced for the Welfare Administration, U.S. Department of Health Education, and Welfare, by Plays for Living, a division of the Family Service Association of America.

The Office of Education has awarded more than \$1.1 million to 75 college and universities to train teachers of children with serious speech or hearing defects in the academic year 1965-66. The money will be used to provide fellowships and to meet part of the cost of training new teachers.

IN THE JOURNALS

Role of the Father

John Nash, in the March 1965 issue of the quarterly *Child Development*, concludes that the relative neglect of the father in studies of our Western matricentric society "may have distorted our understanding of the dynamics of development in the rearing of males." ("The Father in Contemporary Culture and Current Psychological Literature.")

The author examines possible historical and social reasons for matricentric orientation, reviews the evidence on the effects of this orientation on the psychological development of boys, and presents some hypotheses about the father's role in child rearing, including—

- In Western society, the father, sole support of the family, delegates child rearing to his wife while he works to support the family.

- Clinical studies and investigations of delinquents suggest that father-child relationships, especially between father and son, may be significant in the development of both social and psychological abnormality.

- Psychosexual difficulties apparently result when a child's major identification is with the parent of the opposite sex.

Well Baby Care

Parents must be taught that the best way to learn how to take care of a baby is to observe the baby, according to Dr. Corbett H. Turner, of Emory University, Atlanta, Ga., writing in the May 1965 issue of *The Journal of Pediatrics*. ("An Approach Toward Well Baby Care During the First Months.") Therefore, the author maintains, parent counseling during the first months of an infant's life should aim at helping parents learn *from the infant*.

Dr. Turner cites several points in support of the approach he recommends:

- Mothers are not generally taught to feel that their observations of the baby are important, an attitude which

often leads the mother into behavior contrary to her inclinations. She may, for example, when trying to learn how to take care of her baby, "spend most of her time looking at Dr. Speek instead of at the infant."

- If, for any reason, a mother feels herself to be inadequate in nurturing, she will almost invariably seek someone to tell her what to do. When she turns to the pediatrician, to whom parents "characteristically look," this may result in excessive telephoning, a resentful pediatrician, disgruntled parents, and unsatisfactory care of the infant.

- Satisfactory care depends on fitting it to the characteristics and needs of the individual infant; and parents, particularly the mother, have the opportunity to learn what these are, while the pediatrician usually does not.

Dr. Turner recommends that the mother can develop a nurturing *modus operandi* of (1) observing her baby and (2) basing her decision on what he needs.

Dentistry for the Handicapped

Drs. Wesley O. Young and John R. Mink, writing in the April 1965 issue of *Rehabilitation Literature*, conclude that "there is reason to believe that many handicapped children do not now receive the oral health care needed for total rehabilitation." ("Dental Care of the Handicapped Child.")

Some children are handicapped primarily by the conditions of their mouths, such as those with disfiguring deviations from normal occlusion. Still others—children with cerebral palsy, for example—may not have special dental problems, but have disabilities making it difficult to provide dental care for them unless special facilities, and dentists with special training, are available. Special treatment (including, on occasion, sedation or anesthesia, partial or general) may be required for mentally retarded children and for children with paraplegia, quadriplegia, multiple sclerosis, muscular dystrophy, congenital

heart lesions, rheumatic fever damage, and disabilities due to poliomyelitis.

Noting that nearly 6,000 children are born each year in the United States with oral clefts, this affliction is discussed as a dental problem, as are neoplasms of the mouth and face, injuries and burns resulting in disfigurement and loss of function, and congenitally missing teeth.

According to the authors, 23 State crippled children's agencies offer dental treatment to children with cerebral palsy, 16 to mentally retarded children, 18 to children with other severe defects. Some handicapped children can obtain care from dental schools, hospital outpatient departments, and special clinics maintained by voluntary agencies such as State and local affiliates of the National Society for Crippled Children and Adults.

"Nevertheless," the authors conclude, "many severely handicapped children probably do not receive regular dental care, particularly those living outside of metropolitan centers."

School for Disturbed Children

A description of the education program in a children's psychiatric unit of a British hospital is given by the teacher-in-charge, Kay Vaughan, in the June 1965 issue of *Mental Health*, published by the British National Association for Mental Health. ("School on a Children's Psychiatric Unit.")

At the hospital in Southern England, two units for emotionally disturbed children, each with 15 beds, are operated by the Department of Child Psychiatry. The children include those with acute anxiety, aggressive tendencies, autism and high distractibility caused by brain damage.

Schooling in the units is provided under the hospital's policy that it is important in the process of getting well—and as a steppingstone to a return to outside school, particularly for "school phobics" who may have refused to attend school for a long time.

Diagnosis, testing, and remedial treatment continue at the units along with the schooling.

A few of the children are in school all day, but most are taught for only a part of the day, their disorders preventing them from being able to cope with full-time school.

In addition to learning what they can absorb of the three R's, the children

carry out a number of creative activities—preparing a guidebook on the sights of the city, getting out a newspaper, holding art shows, acting in plays, forming clubs.

"Success," writes Miss Vaughan, "is measured by each child's achievement, according to his ability and mental health at the time."

Helper Therapy

Noting that "an age-old therapeutic approach is the use of people with a problem to help other people who have the same problem in more severe form"—as in Synanon (for drug addicts), Recovery Incorporated (for psychologically disturbed people), and Alcoholics Anonymous—Dr. Frank Riessman, associate professor, Department of Psychiatry, Albert Einstein College of Medicine, writing in the April 1965 issue of *Social Work*, states that "perhaps social work's strategy ought to be to devise ways of creating more helpers." ("The 'Helper' Therapy Principle.")

Dr. Riessman suggests that social work should seek to find ways to transform recipients of help into dispensers of help, thus reversing their roles; and that, in the development of this technique, helping situations should be structured, where possible, so that the

recipients will be placed in roles requiring the giving of assistance.

He refers to current use of this principle in schools, mentioning specifically an experiment in Flint, Mich.

Noting that one of the best ways to learn is to teach, Dr. Riessman points out that the principle could have wide application in hospital groups, prisons, correctional institutions, and so on. He calls for "conscious planning" toward structuring groups for the widest possible distribution of the helper role.

Juvenile Court Judges

Following a survey of the more than 3,000 men and women who perform the function of juvenile court judges in the United States, part time or full time, Shirley D. McCune and Daniel L. Skoler, writing in the April 1965 issue of the quarterly, *Crime and Delinquency*, concluded that "it is a judiciary not adequately compensated" and that it exhibits "striking internal variations" which seem to follow the size of the jurisdiction—i.e., the population served—with the least favorable conditions existing in the smaller or rural courts. ("Juvenile Court Judges in the United States—Part 1: A National Profile.")

The authors report that their survey was based on completed questionnaires

received from judges in all 50 States, the District of Columbia, and Puerto Rico.

Mean annual income for the total group was found to be \$12,490, with rural judges (serving populations of 20,000 or less) averaging \$6,056 and metropolitan judges (populations of over 200,000) averaging nearly three times as much—\$19,220.

"What stands out," the investigator wrote, "is that juvenile court judges as a group remain underpaid, both as judges and as members of the legal profession."

As to staff resources, 33 percent of the full-time juvenile court judges indicated that they had no probation officers or social workers—in rural courts the comparable figure was 54 percent. Eighty-three percent reported that they did not have any psychologists or psychiatrists.

As to key problems, the judges in large jurisdictions indicated the most pressing to be the lack of foster home placement facilities, the need for improved correctional facilities and for additional probation services. Judges in small jurisdictions stressed the need for detention and shelter care facilities, the insufficiency of foster home facilities, and the need for "more knowledge about the right way to handle cases."

Guides and Reports

DAY CARE: AN EXPANDING RESOURCE FOR CHILDREN. Child Welfare League of America, 44 East 23d Street, New York, 10010. 1965. 75 pp. \$1.50.

The nine papers in this monograph focus on ways to expand day-care programs as (1) a protective service for children and (2) a preventive service for their parents.

PERSPECTIVES ON ADOPTION RESEARCH. Introduction by Henry S. Maas. Child Welfare League of America, 44 East 23d Street, New York, 10010. 1965. 64 pp. \$1.50. Includes four papers exploring the

current status of adoption research and areas for future study, theoretical issues and approaches, methodological needs, and the value of adoption studies to the practitioner.

PUBLIC SCHOOL CLASSES FOR THE EMOTIONALLY HANDICAPPED: A Research Analysis. William C. Morse, Richard L. Cutler, and Albert H. Fink. The Council for Exceptional Children, National Education Association, 1201 16th Street NW, Washington, D.C. 20036. November 1964. 142 pp. \$2.50.

A nationwide study of 117 special classes for emotionally handicapped

children, which concludes that although "the programs are doing some good . . . the research reveals an amazing lack of specific pattern and uniformity approach."

PROCEEDINGS: INTERNATIONAL COPENHAGEN CONGRESS ON THE SCIENTIFIC STUDY OF MENTAL RETARDATION (Vols. 1 and 2). Edited by Jakob Øst with the assistance of Henning Sletved. Statens Åndsvægeforsøg Falkoner Allé 1st, Copenhagen, Denmark. 1965. 895 pp. \$5.

Included are the 159 papers presented at the congress in Copenhagen August 7-14, 1964, sponsored by the International Association for the Scientific Study of Mental Deficiency. The report research on the genetic, medical, psychological, educational, and social aspects of mental retardation.

READERS' EXCHANGE

Memories of Frances Perkins Secretary of Labor, 1933-1945

KATHARINE F. LENROOT

Former Chief of the Children's Bureau

[FIRST met Frances Perkins as Grace Abbott and I, and thousands of others, were walking down Pennsylvania Avenue in Washington, D.C., on our return from President Roosevelt's first inaugural. As a member of the incoming Cabinet she was on her way to luncheon at the White House, but her automobile was stalled in the traffic. Seeing this, we stopped to chat with her for a few moments. Like all the others in this great throng, we had just been greatly stirred by the new President's call to conquer fear—"the only thing we have to fear is fear itself." On this rather slight and feminine person rested a large share of responsibility for helping him to give leadership in removing as far as possible the burdens of uncertainty and anxiety carried by all the people and of extreme deprivation borne by the unemployed and their families.

In writing of those days in March 1933, Miss Perkins spoke of the two great terrors that had to be faced—unemployment and the money crisis. "We had," she said, "to work out a plan of cooperation between natural economic laws and social needs." ("People at Work," by Frances Perkins, John Day Co., New York, 1934.)

The "conference method"—bringing together representatives of all interested groups—she adopted as one of the principal techniques of the Department of Labor for achieving its objectives. To her part in the task she brought both a New England conscience and true Yankee realism; a living faith in God and in the potentialities and in-

herent good will of most men and women; a belief in the processes of democracy; sympathetic understanding of and concern for people; a liberal education with advanced study and a wealth of practical experience; keen intelligence; love of beauty; a sense of humor; unswerving courage; and firm loyalty to those she served, the colleagues with whom she worked, and the friends she cherished. These qualities armed her for leadership and participation during 12 years of depression, struggle for recovery, and war.

Among my most cherished memories are the pre-Christmas assemblies of the entire Department of Labor staff in Washington, which she led with reading of the Gospel story and a simple Christmas message which came from her heart.

She built a strong Department of Labor from one which, in some of its aspects, was feebly equipped in legal authority, direction, and personnel. This she did with a minimum of bureaucratic overhead and formalism, and a maximum of direct personal relationship with the people on its staff.

Occupied as she was with the critical problems of economic and industrial life and management-labor relations, she gave unfailing support to efforts to provide greater protection and opportunities for children and young people. Provisions in their interest were included in many of the major pieces of legislation which she helped to mold and for which she carried either complete or collaborative responsibility for implementing. She always had time

for the concerns of the Children's Bureau and devoted many hours to leadership in its conferences and meetings, especially in the 1940 White House Conference on Children in a Democracy.

When it was understood in January 1945 that she had decided, for personal reasons, to ask President Roosevelt to accept her resignation, our hearts sank. Then, one day, on return from the White House, she called in the Department's officials and told us how concerned she was over the weariness of the President, and how she had been unable to say "no" to him when he pressed her to continue in office.

In the foreword to the "Papers and Discussions at the Initial Session of the White House Conference on Children in a Democracy," Miss Perkins wrote:

"Democracy is not only a form of government, it is not only a matter of people living in liberty with each other; there is involved in it the experience of men in liking each other, in getting on together, and in using the friendship so generated to develop a better life and a better relationship for all the people who come after us. We need to take these things for granted in America and go on to see what more we can do with them in behalf of the children of the next generation."

BRIELAND: *Another team experiment*

As the administrator of a large public child welfare agency which is faced with a serious shortage of professionally prepared social workers, I found Donald Brieland's article, "The Efficient Use of Child Welfare Personnel," to be of unusual interest. [CHILDREN, May-June 1965.]

Dr. Brieland's description of experiments employing a team approach to discharge specific child welfare functions promises several kinds of manpower gains. It offers possibilities of conserving the time of fully trained child welfare personnel by assigning specific functions to lesser trained persons. This approach might open the door to extensive and effective use of subprofessionals. Still another gain might be scored by giving more workers stimulation and support as functioning members of a team rather than in isolated solo performance.

Dr. Brieland's article provides encouragement for the prospective joint project of the Kent School of Social Work (University of Louisville) and the Kentucky State Department of Child Welfare. The project would involve the development of training teams or units, captained by jointly appointed supervisors and made up of a graduate student or two, one or two child welfare workers without professional social work training, and a senior undergraduate drawn from the social work sequence of the University of Kentucky.

This would be a service team which would undertake all child welfare functions in the community in which it was located, as part of a carefully designed training program.

The need which Dr. Brieland describes, and the kind of teaching materials which might be more effective in training subprofessionals, will strike a responsive chord in all who carry some responsibility for preservice and inservice training programs in public agencies.

*Richard J. Clendinen
Commissioner, Kentucky State Department of Child Welfare*

RE FOSTER PARENTS: Ideas wanted

We would like to share ideas with other children's agencies concerning ways and means of recruiting, training, and retaining good foster parents.

Our agency has a foster parents' *Newsletter*, published 3 times a year for approximately 500 foster parents. This includes general agency announcements, interpretative articles about child care, and articles written by foster parents themselves. Also, we enlist the foster parents' help in recruiting additional foster parents and give recognition for this in the *Newsletter*. We see this organ as another aid in bringing the foster parents closer to the agency and to an understanding of their important role in our program.

In the 9 years that the *Newsletter* has been published, we have only been able to locate three other agencies with a similar publication. We are sure there are more and would like to exchange issues with them.

However, the *Newsletter* is only one of several methods our agency uses to help foster parents develop their skills in their job of caring for children. In addition to providing them with the regular supervision of a caseworker, the

agency holds group meetings for foster parents, led by our staff development leader. Some are round-table discussions attended by 8 to 10 foster-parent couples, who themselves pick the subjects for discussion. Others are general meetings attended by all the foster parents and are focused on such topics as: "Foster Families, Foster Children's Families, and Social Workers;" "The Why and How of Discipline;" "Rivalry Among Sisters, Brothers, and Foster Children;" "Why Children Ask About Sex."

The women's auxiliary of our board gives an annual recognition party for foster parents, which is a gala affair.

We would like to know what other agencies are doing to improve the supply and quality of boarding homes for children. If any would like to participate in an exchange of ideas, we hope they will communicate with us.

*Doris A. Lawler
Assistant Director, Services for Children, Child Welfare Board of Summit County, Akron, Ohio*

DENNIS: It can be done

Public welfare workers have become increasingly concerned over the fragmentary nature of the various medical services sought out by their clients. The medical services paid for by the agency are generally limited in scope and duration, and the payments are all too often less than the usual charges. Welfare medicine has been described as *symptomatic* medical care, dealing with the obvious partial effects while ignoring the underlying totality of causes. The client is treated by the physician or at the clinic for a virus infection or severe cold, while his developing arteriosclerosis goes unheeded for lack of complete examination.

It is therefore encouraging to read of the active, aggressive interest and participation of a community hospital in raising not only the tone and quality but also the long-range effectiveness of medical care for public welfare clients, as described by Margaret A. Dennis in "Improving Coordination of Welfare and Medical Services" (CHILDREN, May-June 1965). Studies in Pennsylvania and elsewhere have shown that medical problems represent the greatest single barrier in helping public assistance recipients achieve self-support or self-care.

Public assistance recipients in par-

ticular need *comprehensive* medical care, including complete examination and identification of medical problems and early treatment to forestall the necessity for the more complex and costly medical services that are the fruit of neglect. The New York Hospital Welfare-Medical Care Project is providing such care. Similar projects are under consideration in Pennsylvania at the Montefiore Hospital in Pittsburgh and at Temple University Hospital in Philadelphia. The New York Hospital project has shown what can be done but, above all, *that it can be done*.

A comprehensive, hospital-based system of medical care for public welfare clients will undoubtedly raise pointed questions. If assistance recipients are assigned to a hospital for all the necessary medical services, what becomes of the individual's so-called "freedom of choice" of health practitioner? Should public welfare clients be treated differently from others who need medical care? What about the neighborhood physician who will lose a source of income when some, perhaps many, of his patients are assigned to the hospital-based program?

Other, more basic questions may also be asked. Are traditional methods of delivering and paying for medical services the only or the most effective methods in a public medical program for dependent persons? What will be the role of the hospital in the medical care of the future? It is to the credit of the New York Hospital Welfare-Medical Care Project that it was not deterred by these questions.

Can welfare recipients be provided with good-quality medical care, in one place, by the same body of practitioners who know his medical and social problems and needs? Can workers in welfare and medical fields learn to operate effectively, recognizing that the client, with multifaceted problems, nonetheless *one person*? The New York project has answered these questions affirmatively.

*William B. Tollen
Commissioner of Public Assistance
Pennsylvania State Department of
Public Welfare*

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SOME U.S. GOVERNMENT PUBLICATIONS FOR PROFESSIONAL WORKERS

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THE CLOSED, SHORT-TERM GROUP: A Treatment Adjunct for Parents of Mentally Retarded Children. Helen L. Beck. Department of Health, Education, and Welfare, Welfare Administration, Children's Bureau. 1965. 11 pp. Single copies available from the Bureau without charge.

A discussion of the methods, goals, and effectiveness of working with closed, short-term groups of parents to help them deal with problems confronting them as parents of mentally retarded children.

CONFERENCE PROCEEDINGS: THE EXTENSION OF LEGAL SERVICES TO THE POOR. November 12-14, 1964. Washington, D.C. Department of Health, Education, and Welfare, Welfare Administration, Office of Juvenile Delinquency and Youth Development. 1965. 202 pp. 60 cents.

A report on the first nationwide conference called under Federal auspices to explore the possibilities for cooperation

between lawyers and social workers to assure adequate and more effective legal services for the poor. (See "Rights of the Poor," *CHILDREN*, January-February 1965, p. 36.)

The texts of addresses by the Commissioner of Welfare, the Attorney General of the United States, and of all panel presentations are included, together with introductions and summaries of discussions following each panel.

HISTORICAL PERSPECTIVE ON MENTAL RETARDATION DURING THE DECADE 1954-1964; a compilation of articles in *CHILDREN*. Department of Health, Education, and Welfare, Welfare Administration, Children's Bureau. CB Publication No. 421. 1964. 314 pp. \$1.75.

This publication presents 60 articles published in *CHILDREN* between 1954-64 on developments in meeting the problems of mental retardation in children and on related services in maternal and child health and crippled children's programs. It begins with a presentation of the then known causes of mental re-

tardation and ends with a discussion of prospective developments under the Maternal and Child Health and Mental Retardation Planning Amendments of 1963. Also included are a foreword by the Chief of the Children's Bureau and a history of the Bureau's mental retardation activities.

JUVENILE DELINQUENCY SERVICES. Department of Health, Education, and Welfare, Welfare Administration, Children's Bureau. CB Publication No. 421. 1964. 48 pp. 25 cents.

Addressed to citizens and community leaders, this illustrated pamphlet explains the roles of various community agents and services in preventing juvenile delinquency and rehabilitating the youthful offender. It stresses the responsibility of citizen action to see that the community provides the appropriate resources.

THE CHILD WITH A SPEECH PROBLEM. Department of Health, Education, and Welfare, Welfare Administration, Children's Bureau. CB Folder No. 52. 1964. 24 pp. 15 cents.

This pamphlet offers suggestions to parents for helping a child to improve his speech and for recognizing problems requiring the services of specialists. It discusses the emotional and physical origins of various types of speech disorders and the availability of professional facilities for proper treatment.

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by the Ellen Winston, *Commissioner* Katherine B. Oettinger, *Chief*

SEPTEMBER • OCTOBER 1965

AN INTERDISCIPLINARY JOURNAL FOR THE PROFESSIONS SERVING CHILDREN

**A State Plans for Its Retarded
Giving Babies a Healthy Start
Early Blocks to Learning
Raising Children's Aspirations**





VOLUME 12
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BORN TOO SOON, this underweight baby requires the protection of an incubator, close pediatric observation, and highly skilled nursing attention. Intensive

followup of premature infants and efforts to prevent prematurity are characteristics of the maternity and infant care projects described on pages 179-184.

Leopold Lippman was with the California Study Commission on Mental Retardation throughout the life of the commission, from October 1963 to last June. Prior to this, he was executive director of the Washington Association for Retarded Children, with headquarters in Seattle. He has handled special health and welfare assignments in California, has served as consultant to other States in mental retardation planning, and was appointed this September to be California's coordinator of mental retardation programs.



Gunnar Dybwad was for 6 years director of the National Association for Retarded Children, before assuming his present position in Geneva nearly 2 years ago. Previously, he served for 6 years as director of the Child Study Association in New York and for 8 years as director of child welfare for the Michigan State Department of Social Welfare.



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Professor of education and human development at the University of Chicago since 1964, Robert D. Hess has been connected with the university's Committee on Human Development since he obtained his doctorate there in 1950. He has also been a visiting lecturer at the University of Kansas City. Before joining the committee's staff, Virginia Shipman was an instructor in child and educational psychology at the University of Pittsburgh, where she had received her doctoral degree.



Since he conducted the project described here, George Henderson has been appointed assistant director of intercultural relations for the Detroit public schools. He has also received a *Better Homes and Gardens* "Action Award in Education" for the project. Before going to the Detroit Urban League, he was assistant director of the delinquency control center at Wayne State University. For the past 3 years, he has been a part-time sociology instructor there.



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What are some of the problems involved in planning for the mentally retarded? Asked this question by the editor of CHILDREN when California's comprehensive plan, the first in the Nation, appeared, Mr. Lippman prepared the accompanying article on the California experience. The review of the California report which follows this article is a condensation of a critique requested of Mr. Dybwad by the U.S. Public Health Service.

A STATE PLANS FOR ITS MENTALLY RETARDED

LEOPOLD LIPPMAN

*Former Executive Secretary
California Study Commission on Mental Retardation*

ON OCTOBER 30, 1963, less than one week after President Kennedy signed Public Law 88-156, which among other provisions encouraged comprehensive State planning in mental retardation,¹ the California Study Commission on Mental Retardation held its first meeting. Fourteen months later, its final report, "The Undeveloped Resource: A Plan for the Mentally Retarded of California,"² was delivered to Governor Brown and the California Legislature in advance of the 1965 session.

California was able to start and to conclude its comprehensive mental retardation planning 10 to 15 months ahead of the other 53 States and jurisdictions, because the legislature had responded promptly to the challenge of the report of the President's Panel on Mental Retardation, "A Proposed Program for National Action to Combat Mental Retardation," submitted to the President the previous year.³ The President's Panel on Mental Retardation had rendered its report in October 1962, and in the regular session of 1963 the State legislature had created the study commission, charged it to recommend proposed programs, and directed the submission of a final report by January 1965. The legislature had also appropriated sufficient funds for the commission to start its work, so that it was not necessary to wait for the

Federal planning grant due under Public Law 88-156 before getting under way.

As a result of the quick action of the legislature and the Governor in creating the commission, California had the honor to be the first in the Nation to complete its comprehensive mental retardation plan. It also suffered the disadvantages of being first, because it could not profit by the mistakes of others. Nevertheless, its report has received wide and enthusiastic attention. Requests for copies have been received from 30 States.

There were many hurdles in the way of effective planning—semantic, statistical, fiscal, administrative, and political, among others. The commission chairman himself repeatedly expressed the view that the very commission structure was inappropriate to the task. Nevertheless, this was the machinery the legislature had created; these were the individuals the Governor had appointed; and the members of the commission cared enough about the subject to do their best with the assignment.

Learning the Facts

The first problems had to do with facts: How many retarded persons are there in California? What are their needs? What services now exist?

And (as a basis for legislative recommendations) what do the current statutes provide?

The last two questions were the easiest to answer. They required a great deal of careful, painstaking work, the final results of which were neither polished nor wholly satisfactory, because of time and other limitations, but some usable answers were available. To get the facts on present services, the commission created a committee which inquired about programs of State departments and local public and voluntary agencies in 11 counties. The resulting report⁴ was published about midway in the commission's work. It proved to be a valuable document.

The matter of existing statutes was a deceptively simple question, because the State's laws go back many decades, provisions affecting the retarded appear in many codes uncoordinated with each other, and terminology varies widely. Nevertheless, a skilled legal researcher, working under the direction of the commission chairman, himself an attorney, produced what has proved to be the first summary collection of statutes on the subject anywhere in the United States.⁵ The compendium directed attention not only to the statutes dealing specifically with the retarded, but also to oblique references and even omissions which might affect the rights of the retarded.

It was the first question, however, that was the trickiest. To determine how many mentally retarded persons there are in California, it is necessary to count them. But, dealing with the difficult question of how requires first facing the challenging one: Count whom? Probing this problem revealed a more basic one: To deal realistically with mental retardation, one had to define it. This proved a knotty point throughout the life of the commission.

Prevalence clearly depended on definition. A different concept—even a few words changed—would yield different figures, and thereby a different statement of the extent and nature of the problem. The commission rejected intelligence quotient as the criterion, but even such a simple numerical device poses problems. Should the cutoff point be IQ 70? Or 75? Or 85? The difference in prevalence figures is enormous, especially in the upper ranges—and the nature of the problem changes substantially.

The study commission looked at many different definitions, including the 4-ply criterion index developed in Delaware by Jastak and his colleagues.⁶ The commission also reviewed the few community prevalence studies which have been conducted over the years. A highly sophisticated project was under way in Riverside, Calif., under the direction of re-

search workers from Pacific State Hospital, but the results were not available in time for the commission's report.

In the end, after much consultation and thought, the commission accepted the language which had been developed by the American Association on Mental Deficiency: "Mental retardation refers to subaverage general intellectual functioning which originates during the developmental period and is associated with impairment in adaptive behavior."

This was at least a working definition; but the problem still remained to discover reliable prevalence figures. Despite all available information, including some preliminary data from the Riverside study, the commission found itself short of hard facts. Clearly it was impossible to survey the actual population of California in the time available. The commission was unwilling to accept the widely used prevalence figure of 3 percent, because the meager evidence available suggested this was too high. Still, it had no reliable substitute.

After considerable research, and much debate within the commission, it was agreed that the prevalence (if not the incidence) of mental retardation varies with age, and that therefore a single percentage figure would not apply. The commission agreed that the prevalence figure might reach 3 percent for school-age children, but that it would be much lower for newborns, rising among preschool children and tapering downward for adults. This concept produced an irregular curve which peaked during the age span 8-16. Included in this concept was the idea that the individual may move in and out of the group called "retarded" in the course of his lifetime, depending on the degree of his handicap in relation to the demands posed by society and the availability of resources to help him become self-sufficient.

A Sociological Problem

Related to questions of definition and prevalence was a sociological problem. Should the culturally disadvantaged be counted among the retarded? Their environmentally caused lag is not the conventional mental deficiency, and yet their performance in school and their potential as adults are distinctly lower than the average among their peers. The commission noted that low income, poor housing, and inferior medical care have marked adverse effect on intellectual development. Therefore, it offered a series of recommendations, including the provision of earlier and more regular prenatal care, direct social services to indigent families and children, re-

Principles Expressed in the California Report on Mental Retardation

The State of California accepts a responsibility for its mentally retarded citizens. . . .

The Study Commission believes that:

1. Mental retardation is a social problem. Every retarded person and his family are entitled to the concern and assistance of the community, expressed through public and voluntary resources, as is their right, as citizens of the United States and of California.

2. Where necessary, the State must share the obligation of society.

3. The best hope is prevention, and it is our responsibility to develop new knowledge through research and to apply promptly. Meanwhile, we have an obligation to the retarded who are ready with us.

4. There is some potential for growth in every human being. For each per-

son, society should provide the opportunity to develop to the limits of his capabilities.

5. Services should be planned and provided as part of a continuum, which means that the pattern of facilities and eligibility shall be so complete as to meet the needs of each retarded person, regardless of his age or degree of handicap, and at each stage of his life development. . . .

6. Because the retarded person is a human being first, and a handicapped individual secondarily, he should have access to all the general community services that he can use in common with others. Only when integrated services fail to meet his needs should there be specialized services.

7. Services for retarded persons should be close to their homes and families.

. . . . Moreover, no retarded person should enter an institution who can be cared for in the community, and no one should remain in an institution who can adjust outside.

8. . . . Research and professional training are two essential components of the total program, and a pattern of services is incomplete without them.

9. Retarded persons, or their families acting in their behalf, should have substantial freedom of choice among public and private services. This accords with the dignity of the individual and his right of self-determination for his own life.

10. The State should provide for and encourage creative flexibility in all programs operating for the mentally retarded in California.

hining of adults for new job opportunities, and compensatory education for retarded children coming from disadvantaged homes.

Fortunately, positive efforts were already underway in California to provide compensatory education programs with the use of the Federal support available under the Economic Opportunity Act. The commission's observations were helpful as reinforcement in getting these programs established.

Administrative Problems

Planning had to take place in an administrative and historical context, yet not necessarily accept the existing pattern as best.

In his charge to the commission at its first meeting, the Governor said:

"You are not bound to any past or present pattern of services nor, certainly, of administrative organization."

However, this was easier to say than to observe, among the general public—and to some extent within the commission—it was assumed that the department which operated the State hospitals had primary and indeed exclusive concern with the mentally retarded.

The fact was, of course, that far more retarded children received direct services in public schools throughout the State than in the State hospitals; and beyond this, with the exception of scattered community services supported in part with State funds, such as a few diagnostic clinics and sheltered workshops, there were no public services for the huge majority of California's mentally retarded children. Nevertheless, the stereotyped reaction was: "It's the problem of the Department of Mental Hygiene. Let's leave it there." The commission found it difficult to break through this pattern of thinking and at the same time retain the valuable existing services, the body of professional competence, and the intricate network of human interrelationships which had been built up over the years.

The problem was solved in part, and in some degree unfortunately, by circumstances. During the active life of the commission, three men served successively as directors of the Department of Mental Hygiene. All were first-rate officials who, although actively interested and cooperative, were, for obvious reasons, preoccupied with larger concerns. It was thus difficult to maintain momentum or continuity

in the relationships between the commission and the department. As a result, what might have been an unhealthy domination of the commission by one department became instead a partial vacuum which actually diminished the commission's effectiveness in planning.

There was another aspect to interdepartmental relations as they manifested themselves within the commission. The law specified that the directors of five State departments should be members of the commission. (These were education, mental hygiene, employment, public health, and social welfare. A sixth, rehabilitation, was later added by amendment.) One of these, the superintendent of public instruction, was an independently elected official; the others were appointees of the Governor. Most of the departments represented had pre-existing concern with services for the mentally retarded, in some cases involving budgets of millions of dollars.

Experience with bureaucracy would lead one to expect that under such circumstances there would be a struggle for enlargement of power. In the field of mental retardation, however, it appears that the customary rules do not always apply. Rather than empire building, there seemed to be some tendency to avoid additional responsibility. Departmental spokesmen on occasion would suggest that particular tasks be referred elsewhere. To be sure, these views were expressed from the honest conviction that the proposed services would not fit into the existing pattern, but the effect was to reject new program ideas and leave them in limbo.

The question of each department's role was part of a large challenge the commission faced: How to deal with the power struggle inherent in diverse professional viewpoints and organizational interests?

The Governor settled part of this problem by his selection of persons to be appointed to the commission. For members "representing the general public," he could have selected six persons whose chief qualification was a concern for the civic welfare. He did not do so. Instead, for the most part, he chose persons with substantial involvement, and hence strong convictions, in the field of mental retardation.

The Governor might also have selected persons to represent organizations with a stake in the problem. This again he did not do. His decision created some problems, in that certain organizations felt they had been deliberately omitted and therefore slighted; but it also freed each member of the commission to act from his own convictions rather than as an organizational representative.

Jack Halpin, the commission chairman, and I, as the executive secretary, did feel that the commission would have been stronger if its members had included a designated representative of the largest single interest group, the organized parents of the mentally retarded. Several members of the commission were parents of retarded children, but they were not selected to be organizational representatives. They served as individuals, drawing on their personal as well as their civic experience. (In its recommendations for a permanent planning mechanism, the commission later specified a representative for "the consumer"—by which it meant parents of the retarded so designated.)

As chairman, the Governor chose a man with training in the law and political science, and with judicial experience. By temperament, the chairman was forceful individual, intelligent, with a respect for research, and yet one who believed in vigorous action. He was constantly striving for the imaginative approach, the innovation, the creative solution. Some of his proposals startled other members of the commission and the public, but shocked people into thinking for themselves and coming up with workable alternatives.

State Responsibility

A major issue in planning for more effective services to the retarded is whether such services are primarily a State or a local responsibility. This is doubtless being debated in State planning bodies throughout the Nation. In California, there is special accent on the issue in the impressive growth since 1957 of community mental health services. Under the Short-Doyle Act, the State financially assists local governments in establishing locally controlled mental health programs.

To a considerable extent, the question is part of a larger philosophical and political one, having to do with the appropriate roles of Federal, State, and local governments. The California Study Commission on Mental Retardation confronted the issue directly and answered it forcefully in the opening sentence of its report:² "The State of California accepts a responsibility for its mentally retarded citizens."

Despite the vigor of this assertion, there was marked difference of viewpoint among commission members, some of them contending most earnestly that responsibility and power should rest in the counties and the communities. In its report,² the commission did say, repeatedly, that services for the re-

dered and their families should be close to home, and that communities should take initiative, but it placed final responsibility at the State level.

Continuity and Coordination

Determining the specific services which the State and the communities should make available to the mentally retarded was relatively easy. The guidelines in the work of the National Association for Retarded Children, the President's Panel on Mental Retardation, and other authoritative bodies were clear enough. They simply required adaptation to the peculiarities of California's situation.

Tying these services into a usable package was, however, a more difficult task. From the outset, the commission struggled with the core question of how to effectuate the necessary "continuum of services," how insure that the retarded individual receives what he needs at each stage of his life development? How provide a balanced program of services available to everyone who needs them? How avoid a domination of the service program by one agency, either at the State or the community level? How coordinate service agencies which are essentially independent of each other? And, as important as any question, how incorporate the citizenry into the planning which must go on if services are to change in response to changing needs?

To protect the individual retarded person and assure continuity in his life, the commission recommended establishment of regional diagnostic and counseling centers. The coordinating mechanism was harder to find. The commission's answer was Mental Retardation Program Board.

Under the commission's proposal, the board would be established by the legislature and its members would be appointed by the Governor, who would also designate the chairman. The board members would include representatives of all State departments having responsibility for services to the retarded; local government units; voluntary organizations; and the "consumers" of services. Responsibilities of the board would include coordination of existing services and stimulation of new programs to meet discerned needs; development and periodic revision of a comprehensive plan for services to the retarded; setting and enforcement of standards for all such services; and leadership liaison with community mental retardation planning bodies. The board would employ an executive secretary but would not operate programs and therefore would not need a large appropriation for its own work. It would exert consider-

able influence, however, in its review of departmental services and proposals, and in its recommendations to the Governor and the legislature.

The most unusual single feature of the Mental Retardation Program Board, as envisioned by the study commission, was to serve as a contractor in purchasing services for mentally retarded persons. In this role, the board would have fiscal responsibilities and would have the power to assign and reassign programs among departments as part of the continuous planning process. In accordance with the commission's emphasis on the importance of providing a variety of alternatives and on the need for flexibility, the board would have power to enter into contracts with either public or private service agencies at either the State or local level.

The board proposal, the most striking innovation of the commission's work, proved also to be the most controversial. In acting on this recommendation, the legislature made the board advisory only, and stripped away its proposed powers to assign and reassign programs among State departments and to serve as contractor in the purchase of services for the retarded. Instead of an executive secretary to the board, the new legislation provides for a coordinator of mental retardation programs. It does, however, provide that the departments of State government may enter into a joint powers agreement. This provision, which emerged as an amendment to the original bill, may prove to be the vehicle through which more efficient organization of services is achieved.

Priorities for Action

Once the framework and the broad pattern of a comprehensive program are set, how does the planning agency move toward realization of its recommendations? The study commission's expiration date was written into the law which established it in 1963; but from the beginning it was obvious that the recommendations would not be in effect when the commission went out of existence in June 1965.

The commission met this problem with a two-barreled answer. First it recommended establishment of the Mental Retardation Program Board, which would have the ongoing function of planning for the mentally retarded. Then, because the program board could not come into existence until the legislature acted, the commission took upon itself for 1965 the board's function in offering priority recommendations for the legislature's immediate consideration.

For fiscal year 1965-66, therefore, the commission

selected from among its more than 60 recommendations⁷ which it considered most needful of attention and action. These included establishment of the diagnostic and counseling centers, development of new types of residential facilities, provision of rehabilitation services, strengthening of special education programs, establishment of development centers for children unable to attend the public schools, and important steps toward professional training and encouragement of research.

To each of these priority recommendations the commission attached the most realistic price tag it could compute. Its report noted that the total cost of the proposed new services in the first year would be less than 4 percent of what the State of California was currently spending for the retarded. The section on priority recommendations concluded:

The new approach will open doors for better services, so that California can offer real hope to the mentally retarded and their families. Ultimately, through rehabilitation and through prevention, the State will serve its people better and will reduce the cost. Enlightened, efficient programs for the mentally retarded are sound public economy.⁸

Mobilizing Support

From the beginning of the commission's work, it was obvious that consensus among the members in developing a comprehensive plan would not be enough. It was necessary to insure acceptance of the recommendations by the Governor and the legislature, or the whole effort would be merely a sterile exercise. Because the commission itself, as a group, had little or no political strength, it had to conduct its work so as to mobilize support along the way. Many of its activities were designed to this end.

At every stage, the commission invited the viewpoints of professional people and interested citizens. There were frequent consultations with administration officials and legislative leaders. All commission meetings were open to the public; in addition, there were two all-day public hearings at which individuals and organizations were encouraged to express their views. The development of a complimentary mailing list, including everyone who asked to be included, led to an active interchange of views between the commission and its constituency.

Finally, after six full-scale meetings and innumerable other discussions, the commission took its tentative conclusions and recommendations to the people of California through regional workshops. The workshops were conducted by the University of California Extension, which arranged for the fullest circulation and discussion of the commission's proposals,

in a neutral, dispassionate setting. More than 1,800 persons attended the workshops, held on 6 successive Saturdays in different parts of the State; and the reactions had a significant influence on the commission's final report. The effect was reciprocal, for, as people observed the earnestness and sincerity of the commission, and they saw their ideas being accepted, they were enlisted among the supporters of the commission's program, thereby building up statewide enthusiasm for its recommendations. This was reflected in newspaper, radio, and television coverage, and later in expressions of opinion to the legislators.

At one point in the commission's deliberations about the time the crucial issues were coming up for decision—the astute chairman asked a question of central importance: Should the commission work toward the development of the "ideal" plan for meeting the needs of the mentally retarded persons of California? Or should it build into its report the compromises and awareness of political realities which would give the proposals a real chance of enactment?

Two members of the commission responded immediately, almost as if by conditioned reflex. One (the mother of a retarded child) said, "Let us start the ideal." The other (a member of the legislature) said, "Let's build the political realities into the report." Consensus seemed to go with the political sensitive member of the commission, and so—although long-range objectives were stated in the final report—the immediate priorities were keyed to what seemed realistically attainable.

There were legislative obstacles, in some degree peculiar to California, in the year 1965. A knowledgeable observer of legislative trends remarked wryly, early in the session, that although every session was unique, this one was "more unique." In most States, the problem will be different, as the comprehensive mental retardation planning bodies will conclude their work late in 1965 and will then have to wait for the next biennial sessions of their legislatures more than a year later, in 1967. This may result in a cooling-off, or loss of enthusiasm and of popular support. In California, the study commission certainly hit while the iron was hot, bringing in its final report at the beginning of the 1965 session and at the peak of nationwide concern, but it did run into some obstacles not of its own making.

The problem with which the members of the legislature were most concerned in 1965 was reapportionment, which, because of a court order, necessarily occupied the central attention of most of the legislators in the first months of the year. This had nothing

still to do with mental retardation, and yet the effect on the commission's program was substantial and for the most part destructive. The other big problems which impinged on the mental retardation proposals were the size of the total State budget and the need for new taxes; and while these are perennial, they seemed to be especially acute this year. The study commission could do nothing about any of these large problems—nothing but wait, and try to build public support, and hope.

In the end, the legislature enacted every bill put before it as a direct result of the commission's work. Some of the measures were diluted, and the funds available proved to be less than the commission thought necessary, but at least the principles now stand in the law. To this extent, California has taken substantial steps toward meeting its obligations as an affluent State in serving its less fortunate members. Those recommendations of the California Study

Commission on Mental Retardation which are still unrealized now stand as a challenge to future sessions of the legislature.

¹ Lesser, Arthur J.: Accent on prevention through improved service. *Children*, January February 1964.

² California Study Commission on Mental Retardation: The undeveloped resource: a plan for the mentally retarded of California. Report to the Governor and the Legislature. Sacramento, January 1965.

³ U.S. Department of Health, Education, and Welfare, The President's Panel on Mental Retardation: A proposed program for national action to combat mental retardation; a report to the President. October 1962.

⁴ California Study Commission on Mental Retardation: Report of survey by committee on existing resources, functions, and coverage. Sacramento, June 1964.

⁵ ———: Mental retardation and the law: a survey of California laws affecting the mentally retarded. Sacramento, July 1964.

⁶ Jastik, Joseph F.; MacPhee, Halsey M.; Whitteman, Martin: Mental retardation: its nature and incidence. University Publishers, New York, 1963.

⁷ Heber, Rick: A manual on terminology and classification in mental retardation. *American Journal of Mental Deficiency* (monograph supplement, 2d edition), 1961.

A Critique of California's Report on Mental Retardation

GUNNAR DYBWAD

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THE *Undeveloped Resource: A Plan for the Mentally Retarded of California*, the report of California's Study Commission on Mental Retardation, deserves the attention of mental retardation planners in other States. The report shows the evidence of extensive interdisciplinary and interagency work, and its first major recommendation tries to safeguard this broad comprehensive approach for the future in calling for the establishment, by statute, of a Mental Retardation Program Board, whose members would be appointed by the Governor.

The recommendations soundly specify that the board should have the power to employ staff and so be administratively independent of existing State departments, but that it will not operate any service programs. It would have sufficient powers for effective coordination, including the annual revision of a plan for coordination to be submitted to the California legislature and the Governor as a basis for legislative and administrative changes.

Serious questions, however, must be raised with

regard to the recommendation that the program board be invested with powers in regard to "program assignments and reassessments . . . the power to determine the agency which must accept prime responsibility for the provision of a particular service," since this would clearly be a prerogative of the legislature. Furthermore, a recommendation that the board ". . . serve as a contractor in purchasing services for mentally retarded persons" would strongly impede its function as an impartial co-ordinating body, as it would then compete with the operating State agencies for legislative appropriations. In any case, it is more than likely that the legislature will balk at giving such broad powers to a coordinating body. [And, as the preceding article points out, the 1965 California Legislature did balk at granting the board any of these powers. Ed.]

The study commission also recommended establishing 10 or more regional diagnostic and counseling centers to facilitate casefinding and early diagnosis, stating that such a center need not consist of a single facility or a group of physical structures, but could

consist of a group of services. Significantly, the commission recommended that these centers are to be a responsibility of the State Department of Public Health, rather than of the Department of Mental Hygiene.

While recognizing California's long-established national leadership in special education, the commission called not only for strengthening the existing public school program for "educable" and "trainable" children, but also for extending public schooling for the retarded downward into nursery school, and upward into adult education. (In fact, California already had 26 classes for retarded adults in 1963.) Unfortunately, the report does not make reference to the urgent need for public school classes for the multiply handicapped retarded child.

One area that continues to receive far too little attention, both on Federal and State levels, is the importance of public welfare services in planning for mentally retarded adults. It is therefore most gratifying that the commission's report calls in several places for wider use of public assistance grants and for broadening of State and Federal statutory provisions in this regard. It stresses the importance not only of making sure that special attention be paid to the needs of retarded children in the program of aid to families with dependent children but also of focusing on the help that can be given to retarded parents to improve their ability to maintain a family home.

The commission emphasized two other specific service areas: cooperative programs between the State Departments of Social Welfare and of Rehabilitation for the development of sheltered workshops for the retarded (already under way in California), and the use of public welfare funds to develop group residences for retarded adults.

Residential Facilities

The report makes some intriguing recommendations which deviate considerably from viewpoints formerly held by the California Department of Mental Hygiene, one of the first to designate all its mental retardation institutions as "hospitals." It takes the view that the State hospitals for the mentally retarded should be used only for retarded persons needing hospitalization, "with medical, surgical or psychiatric problems of such scope or intensity as to require care in a licensed hospital, with nursing and medical care prescribed by the patient's physician, and usually requiring considerable professional nursing care."

The report, however, recognizes that some individuals needing such hospitalization might be cared for in local pediatric or general hospitals or "*nursing homes susceptible of conversion from their present programs.*" It needs to be emphasized that the commission, by adding this last phrase (italicized by the reviewer), recognized the undesirability of placing mentally retarded persons into existing nursing homes specifically designed for and experienced in the care of geriatric patients.

On the other hand, the report calls for a wide variety of other programs to provide nonmedical residential care, such as foster homes, including day week arrangements for children who must attend school away from home, community living arrangements for young retarded adults who are working, regional residential centers, and other arrangements. The commission wisely refrained from proposing wholesale removal of residents of existing overcrowded institutions for the retarded to proprietary or county owned nursing homes. Rather, makes the following pointed observation:

At this stage (1964), it is still not clear what types of physical facilities and what program services may be best for each retarded person needing residential care. Moreover, it is not yet possible to tell, even in broad statistical terms, what the need is for each type of facility. Program planning should therefore allow for—indeed, should encourage—experimentation with different types of care, organization and financing.

Regrettably, the report fails to point up the need for the Department of Mental Hygiene to give leadership in stimulating the development of facilities for providing psychiatric counseling and treatment for mentally retarded adults who live in the community.

It is not possible to deal in this space with the many other significant recommendations of the study commission, such as those for public guardianship, home nursing and homemaker services, centers for premature babies, genetic counseling services, and registers of "high-risk" babies. Emphasis is given to community planning and the role of private agencies, voluntary membership organizations, and the churches. The need for financing improved and increased training for professional workers is stressed throughout, and a special section points up the tasks this represents for California's higher education system. Considerable space is given to highlighting the need for research relating to prevention.

In spite of its few shortcomings, the report is a valuable addition to the resources for mental retardation planning.

GIVING BABIES A HEALTHY START IN LIFE

KATHRYN CLOSE

AS I SEE IT, our major contribution is giving babies of disadvantaged families a healthy start in life. This will not cure poverty, but it is a necessary first step in this direction.

The speaker was a Minneapolis obstetrician who works one day a week in a maternity clinic in a neighborhood where incomes have been identified as among the lowest in the city, and rates of birth, prematurity, and infant deaths the highest. He recognized that being born to uneducated, unskilled, and bewildered poverty-stricken parents could in itself be a major handicap for even the healthiest of babies, but he saw their first hope in a healthy birth and the next in education--especially for the parents. "And here," he said enthusiastically, referring to the work of the clinic's nurses, nutritionist, and social worker, "we are making a real beginning."

In this city, the establishment of three maternity clinics by the health department within the past year has been a definite break with tradition. So, too, are the use of a nutritionist and a social worker in the public health setting. The innovations have come about as part of the health department's federally aided maternity and infant care project which got under way in January 1965. Already the project's staff cites numerous instances in which the clinic team has brought about correction of conditions dangerous to the future of an unborn child--conditions which might have remained undetected if the existence of the clinics had not encouraged the mothers to seek early prenatal care.

The project is one of 25 maternity and infant care projects which thus far (mid-July 1965) have been approved by the Children's Bureau for Federal aid under the 1963 Maternal and Child Health and Mental Retardation Planning Amendments to the Social Security Act.¹ Plans for seven others are pending approval. With the exception of a few which are State-administered, the projects are administered by local health departments. They all have the same aim: to improve the health of expectant mothers, reduce infant deaths, and try to prevent mental retardation and other defects in children by providing high-quality comprehensive maternity care, with special emphasis on women in high risk of suffering a pregnancy casualty, and followup care for infants in high risk of developing handicaps. The focus is on mothers and infants in low-income areas where the incidence of births, prematurity, and infant deaths is high.²

Only 11 of the projects have been in operation for more than 6 months. By their very nature they are "reaching out" projects, and while the extent of their reach varies, there is abundant evidence that they have achieved a marked improvement not only in the ease with which pregnant women in areas of poverty can secure maternity services but also in the quality of services available to them and their babies.

For example, 10 rural counties in Georgia, where obstetrical service to the very poor has consisted chiefly of delivery by a granny midwife, are now sending about 600 "high-risk" pregnant women a

DISCRIMINATION PROHIBITED—Title VI of the Civil Rights Act of 1964 states: "No person in the United States shall, on the ground of race, color, or national origin, be excluded from participation in, be denied the benefits of, or be subject to discrimination under any program or activity receiving Federal financial assistance." Therefore, the maternity and infant care projects approved by the Children's Bureau for Federal aid under the Maternal and Child Health and Mental Retardation Planning Amendments to the Social Security Act, like every program or activity receiving financial assistance from the Department of Health, Education, and Welfare, must be operated in compliance with this law.

year to a university teaching hospital in Augusta for complete obstetrical care—prenatal, delivery, and post partum.

In Baltimore, Md., all pregnant women not under the care of private physicians are urged to come to a central maternity center for an initial examination by an obstetrician, laboratory tests, a dental examination, and enrollment in an appropriate maternity service. For high-risk patients this may be in one of the city's five district health clinics with delivery at the city hospital, or in one of four teaching hospitals under contract to provide project patients with complete maternity service. Dental care is provided when indicated.

In Chicago, project-paid staff additions to the city's maternity clinics have helped upgrade the clinics' services and extend their hours; arrangements with 12 teaching hospitals are sparing high-risk obstetrical patients the impersonal treatment of an overcrowded county hospital; and 4 project-established pediatric clinics are providing intensive medical supervision of high-risk babies.

In Detroit, 3 voluntary hospitals, under contract to provide comprehensive maternity service to 3,300 high-risk patients a year, have relieved the load on the health department's only maternity clinic, so its patients can now receive more attention; and home visits to maternity patients and newborns have been increased through a contract with a voluntary visiting nursing service.

The list could continue, with many more examples than there are projects, for, in addition to seeing that high-quality medical and laboratory services are available to pregnant women in low-income areas, the projects are providing a variety of services to help such women seek prenatal care early and regularly in pregnancy, and to provide adequate care for their babies after birth.

Basic requirements are set by the law and by Children's Bureau standards for assuring quality of service. Thus a project's medical arrangements must provide for comprehensiveness, quality and continuity of care, during the prenatal, labor, and post-partum periods; all applying pregnant women living in a project area must be accepted for prenatal care but only "high-risk mothers" of low-income families may have their hospital bills paid by project funds; the locality must put up 25 percent of the total project cost. Since comprehensiveness is interpreted to mean taking into account all the social and health factors relating to the well-being of the expectant mother and her child, comprehensive care is expected to include the services of obstetricians, pediatricians, public health nurses, social workers, nutritionists, laboratory technicians, and clerical and other auxiliary personnel.

Physical conditions, age ranges, and social circumstances associated with a high rate of pregnancy casualty and prematurity are the determinants of high-risk pregnancy and thus may include: toxemia of pregnancy, hemorrhage; dystocia (difficult labor); concurrent medical problems, such as anemia, diabetes, or infections; multiple pregnancy; a history of difficulties in previous pregnancies, in either mother or child; pregnancy in women under 16 or over 40; out-of-wedlock pregnancy. "High-risk babies" may be babies born to "high-risk mothers" or babies in their first year with adverse physical conditions associated with birth.

In spite of basic similarities, each project has distinct character, shaped by its community's specific needs, resources, and problems, and the special enthusiasms of its planners and staff. This is reflected in its emphasis and reach and in the relative measure of frustration and hope in the staff's outlook. Thus in one community where resources for prenatal care were already fairly well-established, a major effort is spent on making their services and their importance known to the women needing them; in another the stress is on the provision of new neighborhood clinics; in still another, parent education is strongly emphasized.

Casefinding and Keeping

Behind the creation of the maternity and infant care program were figures showing a high incidence among indigent populations of births in which the mother received little or no prenatal care, and a high association between the lack of prenatal care and an unfortunate pregnancy outcome. There have been

gements over whether the failure to receive prenatal care lay in the mothers' failure to understand its importance or in the inaccessibility and nature of the facilities offered. The projects tend to tackle the problem from both points of view.

Take, for example, the Baltimore project, where early casefinding is a major goal, but keeping women coming regularly for care is recognized as having something to do with the way services are offered. Here, the project in establishing its central intake maternity center paid special attention to appearance and comfort, with the aim of putting the new patient immediately at ease. Gaily colored couches and comfortable chairs are arranged in informal groupings in a large waiting room. Food-vending machines line the wall, along with literature racks containing simple pamphlets on prenatal and baby care. A fenced-in play area equipped with toys, and sometimes with a volunteer "play lady," is available for children. While the district health clinics are less spacious, for the most part they also have an uncomfortable appearance.

In order to get women to the maternity center early in pregnancy, a social worker and a health educator are working closely together to reach them through established community agencies, schools, civic groups, churches, and block organizations, and through their neighborhood contacts, confidants, and leaders—the beauticians of small hairdressing shops, insurance collectors who call at the home for the weekly premium on a burial policy, ministers of storefront gospel churches, attendants at laundromats. Many of these neighborhood contacts not only pass out the project's literature (soon to include a comic book on prenatal care), but also talk directly to women about the importance of early prenatal care.

Similar reaching-out efforts in Chicago are made through public housing projects, the neighborhood centers of the local antipoverty program, and, among other organizations, those which make special efforts to welcome newcomers to the city—such as the lay Catholic sisterhood and a new resident's committee of a club federation.

In Minneapolis, the clinics stagger their appointments to prevent the long waits which are so often a discouraging aspect of clinic attendance.

For women who for valid reasons cannot make it to the clinic on their own, city projects will pay taxi costs, as they do for transportation to hospitals for delivery or in another emergency. In rural areas, however, other arrangements have been neces-

sary. In Augusta, Ga., for example, where project patients come from as far as 80 miles away, the project has arranged with morticians to transport patients by car or ambulance to and from the hospital for their clinic visits and at time of delivery. To cut down on the chances of births in transit, the project has also established a boarding home in Augusta where patients who are "easy deliverers" can stay when they are approaching term.

This project is now considering the possibility of retraining some of the grannie midwives who have been put out of business by its services, as home-makers to help out families while mothers are hospitalized and when they bring their babies home.

Parent Education

Many people hope that the projects will have a lasting effect in raising the general level of health and child-care practices among the women served. Because of the staff expansion, clinical personnel have more time to explain things to patients and to counsel with them. In addition, nurses, nutritionists, social workers, and health educators are carrying on parent discussion groups, some sporadically, others in a planned, continuous program.

In the hospital-centered project in Augusta, Ga., for example, a maternity nurse whose chief function is parent education is experimenting in the use of closed circuit television to get her message through to expectant and new mothers and to teach other members of the staff the kinds of things that women with little educational background and few resources need to know to prepare for and to take care of a baby. In a series of video tapes, which she and the project's co-director made themselves, she demonstrates in simple fashion how to bathe the baby, what to eat, how to prepare the baby's formula, how to care for oneself in the post-partum period, and how to prepare a layette with available materials—for example, making diapers out of flour sacks and a bassinet out of a cardboard box.

Using the TV showings as a springboard in discussion groups with both inpatients and outpatients, she finds an excellent attention-getter: "When they see me on television, and standing there, a real person, they become fascinated." She is hoping to make a tape on sex education, particularly for the very young pregnant girls who "don't even realize what has happened to them."

This project, like many others, includes aid in family planning as an integral part of its medical care. "And almost everyone who is told about it wants it,"

is the report. Such aid, however, is given only to mothers who ask for it after being informed of its availability.

In Baltimore, a volunteer from the local Planned Parenthood Association mans a booth in a prominent spot at the central intake maternity center and gives information on the various types of methods and materials available. Patients are told they may receive instructions and supplies at their post-partum visit if they so request, and about two-thirds of the mothers have done so. Post-partum visits are scheduled for 4 weeks after delivery, for experience has shown that often after that it is too late to prevent another pregnancy.

Continuity of Care

Continuity of care is approached in different ways in different areas. The ideal—for the mother to have the same doctor for prenatal, delivery, and post-partum care—is rarely achieved, even for those patients who receive comprehensive care through a contracting teaching hospital, since there is usually division between outpatient and inpatient hospital staff. But a degree of continuity is provided in all projects. In smaller projects, as in Minneapolis where the three maternity clinics have only one physician apiece, the expectant mother does have the same physician for her full prenatal and post-partum care. But in other areas, where maternity clinics have large part-time staffs of physicians, some working only a few hours a week, this goal is not always achieved. The public health nurse, who works both in the clinic and out in the neighborhood, then becomes the thread of continuity.

Careful transmission of records from clinic to hospital and back provides another thread; and in some areas a project nurse is located in the hospital of delivery who sees that the records of high-risk patients are called to the attention of the attending physician.

In Baltimore, the project has placed two professional nurse-midwives on the staff of district health clinics to give complete prenatal and post-partum care to patients having no complications. Unlike the physicians, the nurse-midwives work in the clinics on a full-time basis, and so are able to see the same patients at every visit. Their patients have had an above-average record of clinic attendance. On a few occasions, public health nurses have arranged for these nurse-midwives to go into a home to examine a pregnant woman too frightened to attend the clinic. The very "laying on of hands" in these instances, it

is said, produced enough confidence in the women to bring them into the clinic.

The generalized public health nurse is recognized as a key figure in any maternal and child health nursing program; hence the provision of additional nurses for public health units or districts has been an important aspect of most maternity and infant care projects. It is the public health nurse who interview the expectant or new mother at the clinic to be sure that doctor's orders are understood; who visits the home of every registered high-risk patient to learn about conditions there; who follows up on broken clinic appointments; who visits mother and child after their return from the hospital; who gives the mother instructions in the care of herself and her baby; and who calls the social worker's attention to crises or conditions needing social intervention. In addition, through her neighborhood rounds, she is a major casefinder for the maternity clinics.

High-Risk Babies

Babies born of high-risk mothers are usually examined by pediatricians while still in the hospital and the circumstances of the birth—such as a child critically long failure to breathe—or any obvious or suspicious problems are reported to a special followup clinic or the health department's regular well-child clinics. Premature babies are kept in the hospital of birth or at a "premature center" until large enough to be taken home safely.

Only a few projects have thus far established special pediatric clinics for high-risk infants. In Chicago, four such clinics provide complete pediatric examination and treatment and, when needed, the service of specialist consultants for all babies born prematurely, all babies born of high-risk mothers and all babies with birth defects or other conditions obstructive of healthy development. The clinicians are given frequent opportunities to improve their techniques, as in a recent demonstration of a new method of testing infants' hearing.

When a baby's condition in followup is diagnosed as "failure to thrive"—as with an infant who weighed 5 pounds at birth and 4 pounds at 7 weeks—the baby is hospitalized and a public health nurse is asked to make an immediate home visit to assess the situation. The nurse and a teaching homemaker seen by the social worker may be enough to improve the mother's ability to provide appropriate child care. If abuse is suspected the case is referred to the court or to a protective agency.

Far more common, however, are the babies who

rive under their mothers' care because incipient problems were discovered and treated early—the child whose kidney was removed at 5 weeks when a massive growth was discovered; another whose infantile hernia was corrected by surgery; three babies whose eyesight has been saved because in followup discharges were noted, examined, and treated.

Some Problems

Problems faced by the projects are both common and distinctive. A common one is staffing, but its seriousness depends a great deal on the community's customary salary levels. For example, a project in a large city accustomed to meeting physicians' salary expectations has had little difficulty finding pediatricians to staff its infant clinics; but the same project, faced with a failure of the public services to recognize the profession of social work, has thus far been unable to get salaries approved by the city authorities that would attract professional social workers. In another city, with higher social work salaries, the project had only a little trouble filling its complement of four social work positions. And still another project, in a region of low salary levels, finds itself caught in the necessity of competing nationally for highly qualified paramedical personnel and the impossibility of offering a salary above the State's rate.

Another common problem, frustrating in some measure to all the projects, but far more serious in some areas than others, is the inadequacy of community resources to ward off latent human tragedies. What can a social worker do to help a victim of incest? The only response of welfare and court officials in the rural area covered by the project is a shrugging indifference to "these people" and "the way they live"? What can a doctor provide that will keep a baby healthy who, because of community indifference, has to be taken home to live with 17 other people in 2 rooms furnished with 2 beds? (Or, in less extreme instances, to a household of 8 people in 2 rooms, 13 people in 4 rooms, or 10 people in 3 rooms?) Or how can the nutritionist help a pregnant mother, with four children at home, to raise the level of her nutrition, if her public assistance allowance provides for only 21 cents a meal per person in a city where food costs are high? Or what can be done when a hospital requests removal of a baby abandoned by its mother and the local social agencies insist there are no more foster homes or adoptive homes available?

Where community resources are woefully inadequate, the project's social workers tend to become

community organizers seeking out potentialities for promoting services and organizing or joining committees focused on specific needs—such as schooling for the teenage unmarried mother, or the promotion of adoption services for Negro babies. Where community resources are more adequate, the social workers serve as catalysts in bringing need and resource together—occasionally even to the point of personally conducting a bewildered woman to an appropriate social agency. There have also been occasions when the social worker has used his status as a representative of the local board of health to make it possible for families to move from unspeakable housing into better quarters.

More typical, however, are the cooperative arrangements made by projects with local welfare departments. In Baltimore, for example, if home visits have revealed conditions considered detrimental to a newborn, the project will continue to pay for the baby's care in the hospital until the welfare department has made more suitable arrangements.

In Chicago, the welfare department has recruited and trained 10 homemakers for the project. These are assigned by the project social worker to families in emergency need—for example, the family in which a working father, a "high-risk" infant, and his 3-year-old brother were deserted by the mother 4 weeks after her confinement. Most often, however, the homemakers are used for teaching housekeeping and baby care to mothers returning with newborns to badly disorganized households.

Long and tiresome waits, on not too comfortable chairs, as in this picture, have long been the rule in many clinics. Now efforts are being made to shorten waits, through staggered appointments, and to supply more comfortable chairs.



In Minneapolis, all unmarried mothers are referred to the welfare department, which provides them with a special program of casework and other assistance, regardless of legal residence.

In other areas, however, the problem of pregnancy out of wedlock exists in more overwhelming proportions. In Chicago, for example, so many unmarried pregnant women and girls are seen in the health department's maternity clinics that the maternity and infant care project only classifies them as "high risk" if they have physical complications or are in a high-risk age group—over 40 or under 16. The under-16's alone—some in their second pregnancy—present an enormous problem because of the paucity of community resources to help pregnant girls from indigent families prepare for their future and the future of their babies. The project's social worker—so far the only one it has—is working with community groups toward the establishment of a casework and educational program for such girls, and is herself providing as much casework treatment as her organizational responsibilities will allow.

In Baltimore, the chief social worker talks with every unmarried pregnant girl under 17 who comes into the maternity center. He may refer her to the welfare department's child welfare division for protective service, to a voluntary agency for shelter care, or to a hospital for inclusion in a group therapy experiment with pregnant teenagers; or he may himself work with the girl and her parents as they plan for her own and her baby's future.

Problems requiring the social workers' attention are of course not confined to the unmarried. A 34-year-old mother with 11 children, who has not been out of her own yard for 2 years and has never been on a bus, has to be helped to get up the courage to take the trip to the clinic; a young victim of rubella has to be helped to face her firstborn's serious deformity; a pregnant mother of three who has left her abusive alcoholic husband needs help in planning for the future; a nonresident couple, with a premature baby still in the hospital, needs help in finding a way to ward off an impending eviction.

Among the most frequent medical problems encountered in the clinics are anemia and toxemia. Nutritionists report that these conditions are almost invariably related to faulty eating habits, stemming partly from an inability to stretch a meagre food allowance and partly from food preferences which run to an overabundance of starches and sugar—perhaps because of their filling quality. Anemia is also a problem in some high-risk babies.

To counteract the problem of anemia some project supply iron pills to nearly all prenatal patients; and the doctors in high-risk baby clinics tend to prescribe formulas containing iron. At the same time, to bring about salutary and lasting changes in food habits, the nutritionists work through the nurses, through direct counseling with the expectant mothers, through demonstrations of how to prepare nutritious low-cost foods palatably, through the preparation of attractive nutritional materials, and through talks to community groups. Achieving such change, nutritionists report, is especially difficult with teenagers, particularly those pregnant with their second or third child who are "just too discouraged to care whether they lose weight or not."

What It Means

The maternity and infant care program is, of course, essentially a medical program and as such cannot be expected to cure all the ills that accompany poverty. What it does for people, rather than what it cannot do, is what counts. In Chicago, for example, a mother who in past years produced six dead infants has a live healthy baby today because, while he was still a fetus, the project made it possible for him to have one of the latest of medical procedures, an intrauterine transfusion. Another mother, with a history of several miscarriages, today has a healthy infant because an obstetrician in the maternity clinic had the time, in a no longer overrowded clinic, to notice that her cervix was beginning to open long before term and could arrange for corrective surgery. And a diabetic mother owes her possession of a healthy baby to the fact that tests, requiring the use of a laboratory 1,000 miles from the clinic, showed a dropped estriol content in her uterine, a sign of her need for an immediate Caesarean section.

The program's real meaning is perhaps best expressed by the patients themselves: in their behavior as when all the patients of a maternity clinic showed up for their appointments during a blizzard so severe that it kept home all but three members of the staff or by their verbal testimony, as that given by the West Virginia woman who, because of a project, had her ninth baby in a hospital—the first time she had ever been in one. Asked about the experience, she said:

"They kept a dim light on in my room all night, got three hot meals a day, and the kindness of the doctors and nurses I will never forget."

¹ Lesser, Arthur J.: Accent on prevention through improved services to Children, January–February 1964.

IMPROVING PARENT CARE OF HANDICAPPED CHILDREN

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CONFRONTED frequently with major emotional disorders in the *families* of handicapped children, staff at the James Whitcomb Riley Hospital, Indianapolis, Ind., have been troubled by the thought that some secondary handicaps in these children, traceable to their families, might have been prevented. On the premise that such families constitute a population at special psychological risk, the authors of this article have been exploring a number of operational innovations at the hospital, designed to emphasize prevention as well as treatment in rehabilitation programs for handicapped children. Among these is a parent education program opened in 1961 and supported by a grant from the Junior League of Indianapolis.

The term "parent education" emphasizes two basic elements of the program: that it is *parent*- as well as child-oriented and that it involves *education* of the parents as part of the treatment of the child.

The design and objectives of this program have been based on the following observations:

1. *The birth of a handicapped infant precipitates a family crisis.* Whether the family arrives at a healthy or a maladaptive resolution of this crisis may be influenced, in some cases at least, by the intervention of physicians and other health workers.^{1, 2} Parent-child and other family relations become organized, for better or for worse, in the early months, and are difficult to modify later. It is therefore important that the family be seen soon after birth and at fre-

quent intervals thereafter. Many such families are not referred to appropriate centers until "there is something that could be done for the child"—surgery, physical therapy, or bracing.

2. *Lack of communication is a striking deficit.* While the lack of adequate discussion between professional disciplines and between parents and physicians is well known, the uncommunicativeness between many of the mothers and fathers is less appreciated. Often the father almost completely isolates himself from the care of the child, perhaps obtaining a job which keeps him away from home much of the time; less frequently, the mother withdraws from active care of the baby; in still other cases, both parents tend to deny responsibility for care of the baby.

3. *The extent of parental misinformation is often great.* Newspapers and magazines often compound the problem by giving information which emotionally involved parents cannot assimilate without individual help.

4. *Parents of handicapped children often feel markedly inadequate.* The statement, "I just don't know how to take care of a child with this handicap" is not a superficial parental remark. Otherwise resourceful parents seem surprisingly uncertain about growth and development steps and the day-to-day care of their handicapped child. They also seem fearful that they will do the wrong thing—and often do.

5. *Understimulation is a frequent developmental threat.* Such deprivation may occur in the child's

home as well as in the institutional setting. Our experience indicates that the handicapped infant frequently has less contact with his mother than has the normal baby, and that he spends an inordinate amount of his day in a crib, a playpen, or a walker. This kind of experiential deficiency—one to which the handicapped child is especially vulnerable—occurs, in part, because the parents do not know what to do or what to expect. Said a mother of a blind baby, as if this were obvious: "He's blind. He doesn't do anything."

Since the effects of deficient environmental stimulation are more easily prevented than treated, parents of handicapped children need suggestions for providing age-adequate developmental and sensory experiences.

6. The physician has his limitations. The individual physician does not have at his immediate disposal all the services which these families need. The limitations—in part, those of interest, time, professional, and, in the case of teaching hospitals, the limited tenure of residents—are also very much the frequently unrecognized hesitancy of parents to trouble physicians with "trivial" questions, even when these represent truly major concerns. The auxiliary health worker is, in the mind of the parent, often more accessible than the physician.³

The Project

The project has headquarters in the Parent Education Center which occupies two offices adjacent to the outpatient department of the James Whitcomb Riley Hospital. This is a 194-bed children's hospital located on the campus of the Indiana University Medical Center, Indianapolis. The director of education, an experienced pediatric nurse with additional training in maternal and child health, is a member of the department of pediatrics of the medical center and works closely with the director of the outpatient department.

Referrals to the Parent Education Center come chiefly from individual staff physicians, or as part of patient-management programs arrived at in the daily pediatric, diagnostic, teaching-disposition conferences or weekly habilitation review sessions. The director of parent education talks informally with the families of new patients after their arrival in the outpatient department, and is, therefore, able to contribute to the discussions in the diagnostic conference. Many parents also visit the Center spontaneously.

While the parent education project involves all handicapped patients to some extent, staff has become especially interested in blind infants, environmentally deprived children, neurologically impaired babies, and children with cystic fibrosis. An effort is being made to see the parents of such patients as soon after the child's birth as is practical, and at frequent intervals thereafter, especially during infancy and early childhood.

Interprofessional Communication

One of the project's major contributions to the habilitation of children has been its success in reducing the interprofessional communication barrier among various types of hospital personnel, so that the skills of many persons can be brought to bear on the problems of the individual child. The program seeks to provide parents with practical suggestions for immediate, day-to-day problems of child care; suggestions for substitute modes of stimulation in the presence of sensory handicaps; methods of motivating mobility in the child with motor difficulties; and assistance in training for self-care. Such advice is given, as appropriate, by the nurse, the physical therapist, the occupational therapist, the social worker, the speech therapist, the psychologist or the physician. As a result, these disciplines work closely together and so are giving greater help than previously to parents. Since both parents are encouraged to become intimately involved with the child's care, communication within the family is also enhanced.

While an attempt is made to integrate these multiple professional contributions, a certain amour of therapeutic pluralism seems to be important. For example, from the variety of professional contact available, the parents may choose one person with whom to form a close and supportive relationship. In some cases, this is the physician; in others, the social worker, the parent educator, or the nurse. Therefore, for this program to be fully effective, all these professional workers must have a generic core of skills including a knowledge of child growth and development, especially in relation to the handicapped child, interviewing, and principles of parent professional relationships. So far, inservice education of the staff in these areas has largely been accomplished in informal discussions, conferences, and suggestions for reading. Whether more structured training is needed requires further attention.

The integrated series of objective evaluations by the several professional persons available help

parents toward a realistic appraisal of their child's handicap. The physician is also helped in his appraisal of parent-child interaction since the other professional persons who may talk with, and observe, the parents and child can give him their views. The structure of the program also makes it impossible for either the parents or the professional worker to evade important problems for very long.

Pamphlets, books, and other literature are available to parents of handicapped or nonhandicapped children without charge in the Parent Education Center. Fifty different publications are in stock. New publications are screened by the staff, and some of those which appear useful are obtained through the courtesy of the Indiana State Board of Health. Special materials are prepared by the hospital staff where adequate pamphlets are not available. A lending library is also being developed. An effort is made to use literature for parents selectively, at appropriate times, and not as a substitute for help from the physician or other professionals.

Although the project planners initially thought the library would be a major contribution to parent education, experience indicates that it is much less important than the other functions in the program. Noting that nurses and other allied health personnel who visit the Center are interested in these publications, we have come to believe that many of the pamphlets designed for parent education may be more properly employed as refresher texts for members of the staff, who can then communicate their content to parents—or be better prepared to answer their questions.

Movies on Mongolism, deafness, and normal growth and development are available for viewing by parents, individually or in groups. Since few commercially available educational films are appropriate for the purpose of the program, the Center plans to make special films and is at present preparing one which will demonstrate the longitudinal development of blind infants. Photograph albums are also available in the Center to help parents envision what the future holds. For example, an album which depicts the development of an infant with Mongolism in the process of bathing, self-feeding, playing, and being toilet trained has been very useful in this respect.

The Parent Education Center has also organized and directed a number of discussion groups of parents of infants with Mongolism, brain damage, cerebral palsy, and blindness. Some of these group activities have been directed by a social worker with group experience; others, moderated by the present

director of parent education, are directed primarily toward educational, rather than psychotherapeutic, goals. The special advantages and disadvantages of parent groups have been discussed elsewhere.^{4,5}

An equipment loan pool was opened on June 1, 1964, as a section of the Parent Education Center. This facility is stocked with a great variety of equipment—strollers, rollator walkers, relaxation chairs, aspirators, infant seats, humidity tents, nebulizers—which parents may borrow for use in a home program under medical direction. Such equipment not only greatly facilitates the medical plan for the home care of the handicapped child but also serves as continuing and tangible evidence to parents of the support and interest of the habilitation team.

The parent educator also informally interviews parents in the outpatient department in order to gauge their understanding of their child's problems, the questions that need answering, and their ability to participate in the medical program. In doing this, she often gains information about important concerns that the parent will not bring up spontaneously with the physician. Also, parents stop into the Center to ask questions, and to express their puzzlement and frustration in relation to their child's progress. The parent educator, with the social worker, helps them to know what to expect from the physician and the hospital.

Parents often come back to the Center at times of crisis—the death of the child's father, injury of a father in an industrial accident, injury of a child by an automobile. Thus, the parent educator represents a person to whom the family feels close enough to turn to almost automatically at times of acute need. We believe that there is a correlation between such positive professional-parent relationships and the therapeutic alliance of the family with the hospital and physician.

Plans Ahead

These parent education activities are soon to be extended to the community. Although local public health nurses are always contacted by the hospital for followup when the patient comes from distant parts of the State, communication with them is limited. With the addition of a "home-care" nurse in the hospital's outpatient department, as now planned, the extramural program will be strengthened in its efforts to insure that programs developed in the hospital are understood and implemented in the home. The nurse will spend much of her time in the field, to help in the home care of children with such prob-

lems as blindness, cystic fibrosis, meningomyelocele, and congenital heart disease. She will also conduct workshops for public health nurses and others in the community to broaden their roles in the home care of handicapped children.

Another plan is to establish an observation nursery school in the hospital. This facility for handicapped and environmentally deprived children, under the direction of an experienced nursery school teacher, will be helpful not only diagnostically, by assisting the staff to arrive at adequate understanding of a child's problems and capabilities, but also therapeutically, by providing the children with appropriate social group experiences. It will also have a parent education function, since the teacher will use her observations of the children to help their parents understand them.

The work of the Parent Education Center will also be greatly facilitated in the near future by the construction of a "parent-care" pavilion attached to the outpatient department. The patient will stay with one or both parents in this motel-like wing, with diagnostic and therapeutic procedures being conducted in the outpatient department.

The Parent Education Center represents an exploratory attempt to improve services to handicapped children. This developing program is based on the assumption that while the pediatrician has a broad responsibility in habilitation, the provision of truly comprehensive services requires him in many cases to share the treatment role with many other professional disciplines. The mobilization of these resources has been facilitated by the activities of the parent educator. Recognizing the parents to be the most important members of the treatment team, the total staff, working together, attempts to help them be comfortable in making adequate and effective contributions to their child's habilitation.

The program is not devised to substitute for the physician, nor to serve as a stop-gap measure to meet the shortage of physicians; rather, its goal is to enhance the physician's effectiveness by making the care of the handicapped more truly comprehensive.

Services to the handicapped child given in habilitation centers or outpatient departments cannot be fashioned exactly after the model of the private physician's office; their functions are not the same. As Stoeckle has reasoned: "While much of the planning and thinking about outpatient treatment is based on the idea of making it as good as, or like, a private doctor's office, there is a possible development in which the doctor-patient relationship may be less

prominent. This is a program around the concept of therapeutic milieu. . . . This may eventually have repercussions on the one-to-one doctor-patient relationship as the major and preferred mode of therapy."⁶

The purpose of the Parent Education Center in the James Whitcomb Riley Hospital is to provide such a therapeutic milieu in an outpatient department as an extension of services provided by family and hospital physicians.

An important derivative effect of this project is that the pediatric house officer has accepted, at times with enthusiasm, a greater responsibility in habilitation than has been true in the past. Another is the demonstration of the opportunities all professional workers who come into contact with parents have to help parents toward positive rather than maladaptive solutions. Gradually, the various health workers have come to function largely as co-therapists in communication with each other, rather than individual therapists working with the child in relative isolation.

This multidisciplinary approach was obviously not accomplished overnight or without frustrations. The introduction of a new professional role in the complex structure of a children's hospital naturally met with some resistance and many doubts. These difficulties, however, have been surmounted because the parent educator has been able to respect the role of other workers and has had no need to assume their therapeutic "prerogatives."

The parent education program thus seeks to provide family education and guidance for the individual handicapped child by a *family* of therapists. Because this project has had something to offer and because it has had strong medical support, it has gained impressive acceptance by both parents and professional staff and is now regarded as a permanent addition to the services of the hospital.

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EARLY BLOCKS TO CHILDREN'S LEARNING

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IN THE CONTEXT of today's urgent need for preschool education, the central question is: Can we successfully intervene on a massive scale in the cycle of generation-to-generation transmission of poverty and semi-illiteracy? Any answer given at the present time would be based more on optimism than on experience and results. It would be naive, misleading, and irresponsible to make promises of easy success and instant results from large-scale programs intended to raise the educational level of children and families of low socioeconomic groups. There is some reason to be hopeful, but, at the present time, little basis for unrestrained enthusiasm.

Research now under way at the Urban Child Center of the University of Chicago is attempting to reach a greater understanding of two related questions: (1) When we strip away personal concern and sympathy for human tragedy, and after we discard the political slogans, what *is* cultural deprivation and how does it act to shape and depress the resources of the human mind? (2) How does cultural disadvantage affect the mind of the young child?

Our hypotheses are these: first, that the behavior

which leads to social, educational, and economic poverty is socialized in early childhood, that is, it is learned; and, second, that the central factor involved in the effects of cultural deprivation is a lack of cognitive meaning in the mother-child communication system.

We proceed on the assumptions (1) that the structure of the social system and the structure of the family shape communication and language; and (2) that language shapes thought and cognitive styles of problem-solving. In the deprived-family context, this means that the nature of the control system which relates parent to child restricts the number and kind of alternatives for action and thought that are opened to the child. Such constriction precludes a tendency for the child to reflect, to consider and choose among alternatives for speech and action, and develops modes for dealing with stimuli and with problems which are impulsive rather than reflective, which deal with the immediate rather than the future, and which are disconnected rather than sequential.

This position draws from the work of Basil Bernstein of the University of London. In his view, language conditions what the child learns, and how he learns, thus setting limits to his future learning.¹ He identifies two forms of communication codes or styles of verbal behavior: *restricted* and *elaborate*.

Based on a paper presented at the National Conference on Day Care Services. The research described is supported by the Children's Bureau, the Ford Foundation, and the University of Chicago.

Restricted codes are stereotyped, limited, and condensed, lacking in specificity and in the exactness needed for precise conceptualization and differentiation. Sentences are short, simple, often unfinished; there is little use of subordinate clauses for elaborating the content of sentences: it is a language of implicit meaning, easily understood and commonly shared. It is the language often used in impersonal situations when the intent is to promote solidarity or reduce tension. Restricted codes are nonspecific clichés, statements, or observations about events, made in general terms that will be readily understood. By its nature, this mode limits the range and detail of concept and information involved.

Elaborate codes are those in which communication is individualized. The resultant message is specific to a particular situation, topic, and person: it is more particular, more differentiated, and more precise; and it permits expression of a wider and more complex range of thought, tending toward discrimination among cognitive and affective content.

Such early experiences affect not only the communication modes and cognitive structure; they also establish potential patterns of relationship with the external world. One of the dynamic features of Bernstein's work is his view of language as social behavior. As such, language is used by participants of a social network to elaborate and express interpersonal relationships and thus shape and determine these relationships. An understanding of the integral association between language and social structure is of critical importance for an understanding of the effects of poverty upon children. Within the individual family, this association emerges in terms of the principles which govern the decision-making activities, which, themselves, help regulate the nature and amount of social exchange.

Two Family Types

The interlacing of social interaction and language is illustrated by the distinction Bernstein makes between two types of families—those oriented toward control by *status* appeal, or ascribed role norms, and those oriented toward *persons*.²

In status-oriented families, behavior tends to be regulated in terms of role expectations. There is little opportunity in these families for the unique characteristics of the child to influence the decision-making process or the interaction between parent and child, the internal or personal needs of the children not being influential as a basis for decision. Norms of behavior are stressed with such imperatives as

"You must do this because I say so," "Girls don't act like that," or other statements which rely, for justification, on the status of the participants or behavior norm.

In the person-oriented family, the unique characteristics of the child modify status demands and are taken into account in interaction. The decisions of this type of family are individualized and less frequently related to status or role ascriptions. Behavior is justified in terms of feelings, preference, personal and unique reactions, and subjective state. This philosophy not only permits, but demands, an elaborated linguistic code and a wide range of linguistic and behavior alternatives in interpersonal interaction. Status-oriented families may be regulated by less individuated commands, messages, and responses than person-oriented families. (Indeed, by its nature, the status-oriented family relies more heavily on a restricted code; the verbal exchange inherent in the structure, regulates it and is regulated by it.)

These distinctions may be clarified by two examples of mother-child communication, using these two types of codes.

Assume that the emotional climate of two homes is approximately the same, the significant difference between them being in the style of communication employed. A child is playing noisily in the kitchen with an assortment of pots and pans when the telephone rings. In one home, the mother says, "Be quiet," "Shut up," or gives some other short, peremptory command, and answers the phone while the child sits still on the floor. In the other home, the mother asks: "Would you keep quiet while I answer the phone?"

The questions our study poses are these: What inner response is elicited in the child in each of these two situations, and what is the effect upon his developing cognitive network of concepts and meaning?

In one instance, the child is asked for a simple response. He is asked to attend to an uncomplicated message and to make a conditioned response (to comply); he is not called upon to reflect or make mental discriminations. In the other example, the child is required to follow two or three ideas; he is asked to relate his behavior to a time dimension; he must think of this behavior in relation to its effect upon another person; he must perform a complicated task in following the communication of his mother in that his relationship to her is mediated in part through concepts and shared ideas; and his mind is stimulated or exercised (in an elementary fashion) by

more elaborate and complex verbal communication initiated by the mother.

As objects of these two divergent styles of communication, repeated in various ways, in similar situations and circumstances during the preschool years, these two imaginary children would be expected to develop significantly different verbal facility and cognitive equipment by the time they entered the public school system.

In our project, we view the child as an organism which receives a great deal of information of many kinds, much more than he can accommodate. What he responds to, how he interprets stimuli, and how he reacts to it, the child learns in interaction with the environment. In other words, he is taught what to attend to, how to interpret messages, and how to respond. These patterns of cognitive activity, socialized in early experience in the home, become the basis upon which the child's further cognitive development proceeds.

An analysis of language and social structure is necessarily concerned with the consequences of linguistic codes and their accompanying patterns of social interaction upon the developing cognitive faculties of the child. It is our argument that person-oriented families tend to justify behavior and emphasize its consequences; and that status-oriented families ask for rote learning and acceptance of the *status quo*—that is, they use a more rigid learning and teaching model, in which compliance, rather than rationale, is stressed.

The Project

For our research, 160 Negro mothers and their 4-year-old children were selected from four different socioeconomic levels: Group A came from college-educated professional, executive, and managerial occupational levels; Group B from skilled blue-collar occupational levels, with not more than high school education; Group C from unskilled or semiskilled occupational levels, with predominantly elementary school education; and Group D from unskilled or semiskilled occupational levels, with fathers absent and family supported by public assistance.

These mothers were interviewed twice in their homes and brought to the university for testing in an interaction session between mother and child in which the mother was taught three simple tasks by the staff member, then asked to teach these tasks to the child.

One of these tasks was to sort or group a number



As this mother helps her son with a test, they are observed by the investigators who are studying their interactions.

of plastic toys by color and by function. The second was to sort eight blocks by two characteristics simultaneously. The third required mother and child to work together to copy five designs on a toy called "Etch-a-Sketch."

The objective of the project is to relate the behavior and performance of individual mothers to the cognitive and scholastic behavior of their own children. We expect to follow the children of the study through the first 4 years of school, to obtain data on a more complete range of behavior. At our present, relatively early, stage of analysis, data are being examined in terms of social class differences among the four socioeconomic groups of the study—professional (middle), skilled workers (upper lower), unskilled (lower lower), and public assistance (AFDC). At this point in the project, our data about the cognitive behavior and language skills of the children are limited.

The wide range of individual differences in linguistic and interactional styles of these mothers may be illustrated by excerpts from recordings of one of the structured teaching situations, the task of the mothers being to teach the child how to group, or sort, a small number of toys.

The first mother outlines the task for the child, giving sufficient help and explanation to permit the child to proceed on his own. She says:

"All right, this board is the place where we put the little toys. First of all, you're supposed to learn how to place them according to color. Can you do that? The things that are

all the same color you put in one section; in the second section you put another group of colors and in the third section you put the last group of colors. Can you do that? Or would you like to see me do it first?"

Child: "I want to do it."

This mother has given explicit information about the task and what is expected of the child; she has offered support and help of various kinds; and she has made it clear that she impelled the child to perform.

The style of a second mother is not quite so easily grasped by the child. She says, in introducing the same task:

"Now I'll take them off the board; now you put them all back on the board. What are these?"

Child: "A truck."

"All right, just put them right here; put the other one right here; all right, put the other one there."

This mother relies more on physical signs and nonverbal communication in her commands; she does not define the task for the child; the child is not provided with ideas or information that he can grasp in attempting to solve the problem; neither is he told what to expect or, even in general terms, what the task is.

A third mother is even less explicit. She introduces the task as follows:

"I've got some chairs and cars. Do you want to play the game?"

The child does not respond.



Stimulating a child's curiosity about books is one goal of this preschool center. Such programs, research suggests, must also show children how ideas and events are related.

The mother continues: "O.K. What's this?"

Child: "A wagon?"

Mother: "This is not a wagon. What's this?"

The conversation continues with this sort of exchange. Here again, the child is not provided with the essential information he needs to solve or to understand the problem. There is clearly some coercion, on the part of the mother, for the child to perform; but the child has not been told what he is to do.

Each teaching session was concluded with an assessment by a staff member of the extent to which the child had learned the concepts taught by the mother. His achievement was scored in two ways first, the ability to place or sort the objects correctly and second, the ability to verbalize the principle on which the sorting or grouping was made.

Social Class Differences

There were marked social class differences in the ability of the children to learn from their mothers in the teaching sessions. Children from middle-class homes ranked above children from the lower socio-economic levels in performance on these sorting tasks particularly in offering verbal explanations as to the basis for sorting. Over 60 percent of middle-class children placed the objects correctly on all tasks. The performance of children from the other group ranged as low as 33 percent correct. Approximately 40 percent of the middle-class children who were successful were able to verbalize the sorting principle. Children from the lower socioeconomic groups were on the whole, less able to explain the sorting principle. These differences clearly paralleled the relative abilities and teaching skills of the mothers from the different groups.

The differences among the four socioeconomic levels were apparent not only in sorting and verbal skills but also in the mother's ability to regulate her own behavior and her child's in performing tasks which require planning or care rather than verbal or conceptual skill.

These differences were revealed by the mother-child performance on the "Etch-a-Sketch" task.

An "Etch-a-Sketch" toy is a small, flat box with a screen on which lines can be drawn by a device within the box. The marker is controlled by two knobs: one for horizontal movement, the other for vertical. The mother is assigned one knob, the child the other. The mother is then shown several designs which are to be reproduced. Together, they attempt to copy the

odels. The products are scored by measuring deviations from the original designs. The mother decides when their product is a satisfactory copy of the original designs.

These sessions were recorded, and the nonverbal interaction was described by an observer. Some of the most relevant results were these: middle-class mothers and children performed better on the task (14.6 points) than mothers and children from the other groups (9.2; 8.3; 9.5). Mothers of the three lower socioeconomic groups were relatively persistent, eliciting more complete figures than the middle-class mothers; mothers from the middle class praised the child's efforts more than other mothers did, but gave just as much criticism; the child's cooperation, as rated by the observer, was as good or better in low socioeconomic groups as in middle-class pairs; and there was little difference between the groups in affect expressed to the child by the mother.

In these data, as in others, the mothers differed relatively little in the affective elements of their interaction with their children. The gross differences appeared in the verbal and cognitive environments which they presented. The significance of the maternal environment lies not only in the lack of verbal exchange but also in the kind of interaction that develops between learner and teacher. Mothers of blue-collar classes appear to be socializing passive learning styles on the part of the child, teaching him to be docile in such learning situations—in contrast to the more active, initiatory behavior of the child from a middle-class home.

One Question, Several Responses

The women in the study also varied in their perception of school. Applying Bernstein's concept of status-oriented and person-oriented families to our data, we analyzed maternal responses to the question: "Imagine your child is old enough to go to public school for the first time. How would you prepare him? What would you tell him?"

One mother, who was person-oriented and used elaborated verbal codes, replied as follows:

"First of all, I would remind her that she was going to school to learn, that her teacher would take my place, and that she would be expected to follow instructions. Also that her time was to be spent mostly in the classroom with other children, and that she could consult with her teacher for assistance on any questions or problems that she might have."

"Anything else?"

"No. Anything else would probably be confusing for her at her age."

In terms of promoting educability, what did this mother do in her response? First, she was informative, presenting the school situation as comparable to one already familiar to the child; second, she offered reassurance and support to help the child deal with anxiety; third, she described the school situation as one which involves a personal relationship between the child and the teacher; and fourth, she presented the classroom situation as one in which the child was to learn.

A second mother responded as follows to the same question:

"Well, John, it's time to go to school now. You must know how to behave. The first day at school you should be a good boy and should do just what the teacher tells you to do."

In contrast to the first mother, what did this mother do? First, she defined the role of the child as passive and compliant; second, the central issues she presented were those dealing with authority and the institution, rather than with learning; third, the relationship and roles she portrayed were sketched in terms of status and role expectations, rather than in personal terms; and fourth, her message was general, restricted, and vague, lacking information about how to deal with the problems of school, except by passive compliance.

These responses illustrated the tendency for status-oriented families and relationships to restrict the linguistic codes used in communication. The child who comes to school with a status orientation is prepared to engage in rote learning with passive acceptance of school authority in the learning situation. His initiative and participation in the learning possibilities of the school are meager. Not all such children accept the authority of the school in this unquestioning fashion, but they have few alternatives except to resist and rebel. The range of choice open to them is limited by the nature of the cognitive and interactional environment in which they have had experience.

A more detailed analysis of the mothers' responses to this question grouped their statements as *imperative* or *instructive*. An imperative statement was defined as an unqualified injunction or command, such as: "Mind the teacher and do what she tells you to do," or "The first thing you have to do is be on time," or "Be nice and do not fight." An instructive statement offers information or commands which carry a rationale or justification for the rule to be observed. Examples: "If you are tardy, or if you stay away from school, your marks will go down," or "I would

tell him about the importance of minding the teacher. The teacher needs his full cooperation. She will have so many children that she won't be able to pamper any youngster."

Cultural Deprivation

Against this background let us return to the problem of the meaning, or perhaps more correctly, the lack of meaning in cultural deprivation. One of the features of the behavior of mothers and children of lower socioeconomic class is a tendency to act without taking sufficient time for reflection and planning. In a sense, one might call this impulsive behavior, not the acting out of unconscious or forbidden impulses, but a type of activity in which a particular act seems to be unrelated to the act that preceded it, or to its consequences. In this sense, it lacks meaning; it is not sufficiently related to the context in which it occurs, to the motivations of the participants, or to the goals of the task.

This behavior may be verbal or motor and it shows itself in several ways. On the "Etch-a-Sketch" task, for example, the mother may silently watch a child make an error, and then punish him. Another mother will anticipate the error and warn the child that he is about to reach a decision point; she will prepare him by verbal and nonverbal cues to be careful, to look ahead, and avoid the mistake. He is encouraged to reflect, to anticipate the consequences of his action and in this way avoid error.

Recall the example of the mothers and the telephone calls: one child was prompted to relate his actions to those of another person and to a time dimension, to delay, to observe, and to consider the consequences; the other was given a command that called for no reflection and did not require him to relate his behavior to the context in which it occurred. This is a model of a conditioned response, rather than a problem-solving strategy. A problem-solving approach requires reflection and the ability to weigh decisions, to choose among alternatives. The effect of restricted speech and of status orientation is to foreclose the need for reflective weighing of alternatives and consequences. The use of an elaborated code, with its orientation to persons and to consequences (including future), tends to produce cognitive styles more easily adapted to problem-solving and reflection.

The objective of our study is to discover how teach-

ing styles of the mothers induce and shape learning styles and information-processing strategies in the children. The picture that is beginning to emerge is that the meaning of deprivation is a deprivation of meaning—a cognitive environment in which behavior is controlled by status rules, rather than by attention to the individual characteristics of a specific situation, and one in which behavior is not mediated by verbal cues or by teaching which relates events to one another and the present to the future. This environment produces a child who relates to authority rather than to rationale; who, although often compliant, is not reflective in his behavior; and for whom the consequences of an act are largely considered in terms of immediate punishment or reward, rather than future effects and long-range goals.

Program Implications

If this picture is substantially correct, there are several implications for preschool programs.

For example, it would argue that enrichment for the sake of enrichment may miss the point—that it is not additional, or even more varied, stimulation that is needed, but experiences which give stimuli a pattern of sequential meaning. It argues that such programs must not merely teach the child new words, but must show the child how ideas and events are related to one another. And it argues that the transition that a child must make from a cognitive style of immediate reactivity to one of problem-solving must be made by experiences with authority, not with machines.

When the data are more complete, a more detailed analysis of the findings will enable us to examine the effect of maternal cognitive environments in terms of individual mother-child transactions, rather than in the gross categories of social class. This analysis will not only help us to understand how social class environment is mediated through the interaction between mother and child, but will also give more precise information about the effects of individual maternal environments on the cognitive growth of the young child.

¹ Bernstein, Basil: Social class and linguistic development: a theory of social learning. In *Education, economy, and society*. (A. H. Halsey, Jean Floud, and C. Arnold Anderson, eds.) Free Press of Glencoe, New York. 1961.

² _____: Family role systems, communications, and socialization. Unpublished paper prepared for the Cross-National Conference on Research on Children and Adolescents, University of Chicago, Chicago, Ill. February 20-28, 1964.

RAISING THE LEVEL OF CHILDREN'S ASPIRATIONS

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ONE DAY in the winter of 1962, a shabbily dressed, bright-eyed youth said to me with a broad smile: "When I grow up, I'm going to be a doctor."

For an instant, I was not sure what my response to him should be. There seemed to be too many obstacles for him to overcome. First, his family—including 7 brothers and sisters—had been recipients of public assistance for the past 10 years. Secondly, he was a Negro. Either one of these facts, considered by itself, tended to lead to a negative prognosis. I carefully considered them before answering:

"When you grow up, you can be a doctor"

I was not trying to be "nice" or to "spare his feelings." On the contrary, I sincerely believed that the boy could become a doctor. And, more important, I was willing to assist in making that dream come true. Thus began the Detroit Urban League's 1962 Family Life Pilot Project.

Others had designed and executed projects aimed at motivating and helping adults to get off public subsidy rolls. Usually, these had a short-range goal—to produce financially independent families within a short period of time. For the lack of better terminology, such activities have been referred to as "strengthening family life" projects. Among them was a 1960 project of the Detroit Urban League aimed at helping a small group of mothers who were recipients of aid to families with dependent children to become self-supporting.

At the completion of this 1960 project, the staff noted many facts, the foremost being: That it was *too late* to prevent public subsidy from being a way of life for many of the adults. For one reason or

another—functional illiteracy, poor health, or other intrapersonal problems—they had become chronic public assistance cases. Thus, it appeared that short-range projects alone could not significantly curtail the public subsidy caseloads. At best, such projects are more corrective than preventive. Perhaps the more fruitful and long-range approach, the staff surmised, should center on children. For while it may have been too late to change the lives of those adults regarded as "chronic cases," we felt that we still had time to prevent public subsidy from becoming an acceptable or inevitable pattern for their children.

Designing the Project

Our preliminary work on the 1962 project began in September of 1961 when we consulted several sources for guidance—university professors, social workers, books, and journals. It quickly became evident that no one had undertaken such a project. The majority of efforts to raise the sights of children had been designed either for the exceptionally "bright" or for the exceptionally "dull" students in non-welfare homes. None specifically considered the barriers to children's aspirations created by public subsidy. We were told by a number of persons that our proposed project was not feasible. Although we did not find a program guide, we were determined to proceed.

The journals were important, however, in focusing our attention upon levels of aspiration. We came to realize that although chronic public assistance cases may be directly related to easily discernible factors, such as economic and social conditions, they may also be related to the less discernible factor of the individual's *level of aspiration*, the degree of his *ambi-*

tion in a dynamic social situation. Because aspirations refer to the future, we immediately became aware of the fact that the reliability of any aspiration project not connected with a longitudinal study must be limited. Yet, we felt that this was a valid approach to curbing public subsidy cases.

The project we devised centered on raising children's levels of aspiration, specifically in relation to their future vocations. Our initial question was: "How can children predict success or degrees of achievement in tasks in which they have no experience?" The answer to this, the literature revealed, is that the expressed goals (or aspiration levels) of children tend to reflect the mean of performance of the group with which they identify. Or, to be more specific, a child is believed to evaluate his "life chances" in references to those with whom he identifies. Differences in aspiration levels among different groups of children, we concluded, are not so much a function of the children's ages as a function of social and economic strata identification.

Those who warned us against the project used the identification factor as their major argument. Since "welfare children" identify with "welfare parents," they said, such children do not share in the American tradition of wanting to get ahead. In fact, our antagonists maintained that this was generally true of children in the lower socioeconomic classes.

We believed, however, that in spite of social and economic deprivation, children in lower socioeconomic classes often aspire to significantly higher occupational statuses than their parents, and that these upward shifts usually approximate the next higher class—the middle class. We proceeded on the theory that *the difference between middle and lower class children may not be the achievement motive but their structural opportunities*.

At this point, we realized that our role would have to be similar to the role of middle-class mothers who, according to many social scientists: (1) make more demands on their children, especially for evidence of maturity, independence, and achievement; and (2) give more intense and frequent rewards for fulfilled demands. The key to success, we ventured, is that children of low socioeconomic backgrounds must not only be taught to believe in success, but be willing to take steps making achievement possible.

Our interest in level of aspiration was an interest in *reversing* the operation of three well-known principles of motivational psychology: (1) After success, an individual usually will set a higher goal; (2) after failure, his level of aspiration usually will

go down; or (3) after failure, a person may cease having any aspirations at all.

Students of low socioeconomic backgrounds, we reasoned, should be advised that they need not set their sights low or raise them only after achieving success. On the contrary, they should be advised that, *within their mental and physical capacities*, they should pursue the highest levels of their interests at the initial planning stage. Such pursuit, however, must be based in reality; students must realistically expect to fail not once but many times. In essence, our rationale embodied the belief that children of low socioeconomic status should not be channeled into the so-called "lower class jobs." To do so would be to create and bring about a self-fulfilling prophecy that such children are doomed to lower class status. Unfortunately, too many children of low socioeconomic backgrounds are denied the votes of confidence and opportunities of experience that are necessary for success. Parents, teachers, social workers, employers, and even the children themselves are guilty of such denial.

Our rebuttal to arguments against the project was:

"If adults of low socioeconomic background must compete in a basically middle-class oriented society—and they do—then, as children, they must be prepared for such competition. Therefore, because of their relative deprivation, children of low socioeconomic status need not less education, but more; not less motivation, but more."

Arrangements

We decided to secure a sample of 50 students from the Detroit Department of Public Welfare, Bureau of Social Services, the professional casework division of the department. Because of the small size of their caseloads and their intensive casework treatment with assigned families, the caseworkers in this bureau were relied on to select young participants who might benefit from such a program but who, if not stimulated to greater motivation, would probably become welfare clients themselves.

Following a series of meetings with the welfare department officials, we received a letter from the director of caseworkers outlining the following selection procedures:

Our welfare referrals will be children born between March 1, 1946, and September 1, 1948, i.e., some may become 16 before the project is concluded, and some may have just had their 13th birthdays before the project begins.

We appreciated your recognition of our feeling that these children should be helped to seek a "higher level of economic and social achievement rather than 'the highest'" and that these

goals should be 'consistent with their fullest potential'. . . ."

We will initiate the referral process by a home call and a letter in as many cases as possible and solely by letter in others, if necessary. After this step has been taken, we will send you a separate letter for each case, containing (pertinent) social information. . . .

This will be provided with the understanding that it is for your professional consideration, and will not be shared in toto with members of your advisory committee or other lay persons.

We further understand that you will call on the children selected to appraise them and their parents of the nature and hours of the sessions and of their progress. . . .

The department will furnish bus tickets for the children to attend the sessions.

We shall plan to refer one child from each of 50 homes, if possible, but . . . this may not be possible because our present caseload in the two units of the Bureau of Social Services is less than 300 in all, and you have agreed to accept referral of more than one child in a family in order to have at least 50 in the beginning group. . . .

It was agreed at a subsequent meeting that referrals would consist of children (1) from families which had been public assistance recipients for 5 or more years, (2) with no case histories of severe mental disorders, (3) who "appeared" to have the manifest or latent ability to succeed in school.

We discussed the relative advantages and disadvantages of having only children from the public assistance rolls attend the workshop and considered the possibility of arousing guilt, shame, or persecution complexes. We concluded, however, that, as a rule, such children are known by their peers to be recipients of public assistance, that most such children adjust to these conditions, and—as was borne out later—they would enjoy having a workshop especially for themselves. The fact that community leaders thought enough of their potential to arrange such a workshop, it was believed, would override any stigma attached to a welfare-segregated session.

The Children

The initial sample consisted of 56 Negro students, boys and girls, between the ages of 13 and 16. Later, we added 17 white students in order to dispel implications that the "welfare problem" is a "Negro problem." By having a racially mixed sample, we focused upon the problems of "welfare children" and not "welfare Negroes." Sixty-three of the students (46 Negroes and 17 whites) agreed to participate.

The school counselors and principals, using a form that we designed, rated the students' chances, with and without a change in motivation, of finishing high school and, perhaps, going to college. The form also included estimates of the students' future grades, with and without a change in motivation.

The school personnel predicted that *without* a change in motivation, 26 of the students selected for the workshop would *not* finish high school. They also predicted that even with a change in motivation, *none* of the participants would go to college. In terms of grades, the school personnel predicted that even with a change in motivation less than 10 percent of the students would perform above "C" level.

After securing the sample, we obtained commitments from 27 community leaders, representing a variety of professions and occupations, to *talk with* the students about success and failure.

The speakers were told that they would have the task of letting the students know three things:

1. That we (the Detroit Urban League and many Detroit officials) are *sincerely interested* in them;

2. That we *sincerely believe* that it is possible for them to succeed;

3. That for those who show that they want to succeed, we will offer valuable *community assistance*—scholarships, employment references, remedial school assistance. Local universities, business schools, and the Detroit Urban League were among the organizations which offered such assistance. (As it turned out, one student received a high school scholastic scholarship, two received tuition grants from Wayne State University, and the Detroit Urban League gave one student a college tuition grant.)

The 2-hour workshop sessions were set up for 16 Fridays between February 2, 1962, and June 1, 1962, from 4 to 6 p.m. Food was served before the formal sessions began. Each session was divided into two parts: (1) a general assembly for community resource speakers to talk with the students and (2) four small discussion groups, each having an Urban League staff member as a discussion leader. For control, each child was assigned to a permanent discussion group. And for the sake of experiment, we divided the discussion groups into four categories:

1. Twelve students in grades 9 through 12 (6 boys and 6 girls).

2. Twelve boys in grades 7 and 8.

3. Twelve girls in grades 7 and 8.

4. Twenty-seven students in grades 6 through 8. This group contained 18 boys and 9 girls.

Our major techniques were:

1. *Repetition.* The students were told over and over again that it was possible for them to succeed.

This theme was stated directly and indirectly. Vivid examples of known ex-welfare persons (often the speakers) who had succeeded were presented to spark rays of hope in the youths.

2. *Truthfulness.* In citing examples of success, the speakers did not overlook the possibility of failure. Thus, the students were told that every successful person has failed in some endeavor, but they did not give up; that often, in order to succeed, many sacrifices would have to be made—studying longer hours, going without proper diets, and foregoing luxuries.

The youth workshop was organized and carried out under the same conditions as an adult workshop: (1) a preregistration period was held to give the students an opportunity to notify us in advance of their intention to participate; (2) registration lists were maintained outside the door of the meeting room, and students were required to check in at the registration desk; and (3) name tags were given to participants.

Among the 27 resource speakers (two per meeting) were: a physician, who discussed "Anatomy of a Student: Physical and Psychological"; a dean from Wayne State University, who discussed "You and Your Family: Likenesses and Differences"; a representative of the Detroit Police Youth Bureau, who discussed "You and Your Friends: Likenesses and Differences"; the chairman of the University of Detroit's sociology department, who discussed "What Is Failure?"; a judge of the U.S. Circuit Court, who discussed "What Is Success?"; a city councilman, who discussed "Failure and Success: True Life Stories"; the superintendent of the Detroit Public Schools, who discussed "An Educator's Point of View"; the personnel director of General Motors, who discussed "An Employer's Point of View"; and the president of the Wayne County AFL-CIO, who discussed "A Worker's Point of View."

The initial reaction of the students was *status* shock. Most students could not believe that such highly "successful" people were really interested in them. It took one whole session before the students would ask the speakers questions, either during the question period after their presentations or during the small group discussion sessions during which the speakers circulated between the groups.

Fortunately, the status shock wore off quickly and subsequent sessions were characterized by lively questions and answers. The students' questions ranged from "Why don't the teachers like us?" to "Are good grades the only thing that employers look for when

they hire people?" or "Will my home address influence my getting a job?" Although most speakers alerted us before the sessions that they would have to leave shortly after their presentations, few actually left before the sessions ended. They could not, as one speaker stated, "tear away from the kids."

The Discussions

During the discussion groups, the students opened up and "got things off their chests." The adult discussion leaders noted that most of the students wanted to talk about "things"—ranging from themselves to the American society in general. As they talked, they almost immediately revealed that, for the most part they had very low appraisals of their "life chances" to succeed.

Typical responses to the question of why they felt they would not succeed in life were: "Because I've never had anything." Their pessimism was compounded by such normal teenage complaints as: "My parents are old-fashioned and don't understand me; I can't stay out late enough;" "There's nothing for kids to do."

A dangerous thread ran through most of the discussions: "Because we are poor, nobody cares about us—the teachers don't care, the police don't care, my friends don't care, and I don't care." Even those few students who felt they had "someone who cared" seemed to see the world around them as denying their chances of becoming socially acceptable successes. They said they saw in their immediate environments many idle, unemployed youths who had graduated from high school. What, then, could high school diploma do for them? They also told about others who had not graduated from high school but who were earning "fabulous" sums of money in illegal ways.

After one of the speakers, a Federal judge, suggested that many of the people having illegal occupations, expensive clothes, big automobiles, and well decorated houses could not enjoy these items because of running the risk of being caught by the police, some students commented that they would rather be "poor and honest than rich and dishonest."

Although most students expressed desires to become socially acceptable successes, few seemed to have any idea what they would have to do in order to achieve such success. One girl, for example, was overjoyed to learn the steps that she would have to take in order to become a social worker. In their discussions, the students revealed a shocking ignorance of the broad range of middle-class occupation

in our society. The sessions prompted many students to seek out relevant information from school counselors, libraries, and other sources.

The students were praised for whatever progress they showed in the workshop and in school. We seized every opportunity to show them that "somebody *does* care."

At the awards session on June 1, 1962, all of the students received certificates of completion. Ten students also received gift certificates for outstanding workshop participation and scholastic achievement (B+ averages in school). About 150 people—including 60 of the original students—attended the final awards session.

Some Impressions

I would like to be able to say that the project was a complete success. However, in only 16 workshop sessions, we could only begin a much needed task of raising economic levels of aspiration. And, because aspirations refer to future time periods, our appraisal of the workshop to date can consist only of incomplete impressions. The following are some of my immediate impressions of the first workshop.

We know we made some mistakes in designing and running the project—insufficiently broad participation in planning, a lack of alternative schedule for times when scheduled speakers failed to arrive on time, a failure to consider ethnic and religious characteristics in planning the food for the initial sessions, insufficient plans for parent participation, insufficient work with school counselors and with teachers, inadequate time at each meeting for the student discussions, insufficient staff and budget, and in one instance an inadequate discussion leader. We also had difficulties because of the wide radius from which the students came—from 39 schools within a 4-mile radius of the Urban League's office, resulting in many late arrivals from the more distant schools.

Nevertheless, we believe we can identify a number of positives directly associated with, if not resulting from, the project:

1. The racially integrated nature of the project made clear to all who participated in its planning and operation that the public subsidy problem is a *community* problem—not a Negro problem.

2. Our drawing in 120 influential people as speakers and resource persons working directly in the project spread an awareness and concern for the young people in public welfare programs in places where it counts.

3. Many of the students realized for the first time that someone cares what happens to them.

4. On an average, the academic achievement grades of the students were raised slightly—for example, from C to C+ or B to B+.

5. On an average, the citizenship grades of the students were raised considerably, from C to B, from B to A.

6. On an average, the students missed fewer school days during the semesters of the workshop.

7. All of the students wanted to continue meeting in the fall. In fact, they asked to continue throughout the summer. While our program commitments would not allow for a summer workshop, we did conduct a followup workshop in September 1962.

Followup

The students who attended the second workshop were 30 members of the original workshop group who had volunteered for additional sessions. The sessions, less structured than those of the first workshop, continued until June 1963. During the second workshop, we employed both field trips and community speakers. It gradually evolved into a tutoring project which combined the techniques utilized in the pilot aspiration programs as well as direct skill improvement services. Similar tutoring projects for low achieving students were carried on by the Urban League in cooperation with the Detroit Public Schools and Mercy College in 1964 and 1965.

Followup school and home visits were made in December 1964 in regard to the 63 students who participated in the 1962 pilot project raising aspiration levels. We found that:

1. Of the 10 students who had graduated from high school, 2 were in college.

2. While four of the students had dropped out of school, the others, excluding the graduates, were still in school.

3. Of the 49 students still attending school, 11 were receiving above-average grades; 25, average grades; and 13, below-average grades.

The final evaluation will come after the students succeed or fail in their scholastic and occupational endeavors. Hopefully, the project was the beginning for doctors, lawyers, electricians, nurses, and other workers to emerge from public assistance backgrounds. Only time can tell.

BOOK NOTES

THE CHILD. William Kessen. John Wiley & Sons, New York. 1965. 301 pp. \$4.95, clothbound; \$2.95, paperback.

This book is the fourth in the "Perspectives in Psychology" series edited by Mr. Kessen and George Mandler.

Mr. Kessen, a member of the department of psychology, Yale University, describes his volume as "a book of readings in the history and prehistory of child psychology" which are "largely theoretical" but with an "abiding link with practical action." They were all chosen from Western sources, the earliest (John Locke's "Rewards, Reputation, and Curiosity") having been written in 1693 and the latest (Jean Piaget's "The Growth of Thought") in 1942.

The 16 articles are divided under 5 headings: "Precursors: Physicians and Reformers," "Precursors: Philosophy and Teachers," "Darwin and the Beginnings of Child Psychology," "Development and Diversity: 1900-1930," and "Workers of a Grand Design: Freud and Piaget."

The editor provides extensive commentary on both the topic areas of the main headings and the individual articles.

THE NEXT GENERATION: the prospects ahead for the youth of today and tomorrow. Donald N. Michael. Random House, New York. 1965. 218 pp. \$4.95, clothbound; \$1.65, paperback.

A look at what society will be like 20 years from now is provided in this book, which is based on a report prepared in 1963 for the Office of Juvenile Delinquency and Youth Crime, U.S. Department of Health, Education, and Welfare.

The author, a social psychologist, who is a resident fellow of the Institute for Policy Studies in Washington, D.C., predicts that the increased complexity of society will result in more intense conflicts between community interests and between personal and social values. He also foresees radical

alterations in community and family life resulting from new technologies—in cybernetics, communications, biology, and industry.

The first section of the book explores coming developments in the national economy, technology, and the evolution of urban communities; and speculates on what may happen in the developed and underdeveloped parts of the world, as these relate to the possibilities for peace and war. The second section studies trends and circumstances more within the control of the planners of youth development programs—and the related topics of sex, marriage, and education. The third examines prospects in the areas of work, leisure, values, and viewpoints, as they may be influenced by conditions speculated upon in the first two sections.

The book concludes with a summary of what the next 20 years may hold—a picture of an unwieldy society with "overtones of Huxley and Orwell," though "too full of contrary trends and unanticipated consequences for anything so monolithic" as these authors have imagined. Among the prospects: increased welfare problems growing out of the sheer size and complexity of society; and increased differences between the "haves" and the "have-nots," between the educated "elite" and the educationally underprivileged or mentally underendowed; and between the socially concerned and the indifferent.

The author concludes:

"... we must explore, more honestly and intensively than most of us ever do, which of the values and goals that we hold dear are appropriate to inculcate in youth for living in tomorrow's world—or for ourselves to live by in planning for and guiding [youth]. . . ."

ATTITUDE CHANGE AND SOCIAL INFLUENCE. Arthur R. Cohen. Basic Books, New York. 1964. 156 pp. \$2.95.

This volume, a posthumous publication of a late associate professor of psychology at New York University,

summarizes much of the evidence that research has adduced on the topics of attitude change and social influence. Concerned largely with the results of controlled laboratory experimentation, rather than with surveys, the author discussed the results of studies analyzing—in terms of learning, perception, motivation, and cognition—the effectiveness of arguments and appeals, the personality factors underlying the acceptance of influence, the effects of social roles and interactions.

In his conclusion, Professor Cohen noted that the degree to which outer conformity to persuasive appeals is transformed into inner change "is still little understood," but added that "there are hints toward understanding the conditions under which internalization occurs." Further pointing out that little research has been done to examine "the behavior that may follow change in attitude," he suggested: "Until experimental research demonstrate that attitude change has consequence for subsequent behavior, we cannot be certain that our procedures for inducing change do anything more than cause cognitive realignments."

DELINQUENCY AND CHILD GUIDANCE: selected papers. August Aichhorn. Edited by Otto Fleischmann, Paul Kramer, and Helen Ross. International Universities Press, New York. 1964. 244 pp. \$5.

Paul Kramer, one of the editors of this selection of papers by the Viennese psychoanalyst, who died in 1951, explains in the introduction that these essays continue and extend the ideas presented in Aichhorn's best known work "Wayward Youth" (a translation published in 1925, of his *Verwahrlosige Jugend*). Kramer emphasizes Aichhorn's "fundamental view" that delinquency is "a condition the beginning of which reach into the past long before the appearance of actual symptoms."

The book's seven chapters consist of essays on the application of psychoanalytic understanding in dealing with juvenile delinquents, under the headings: "On Education in Training School," "On the Problem of Wayward Youth," "The Juvenile Court: Is it a Solution?" "Reward or Punishment as Means of Education?" "On the Technique of Child Guidance: the Process of Transference," "The Education of the

"Insocial," and "Delinquency in a New Light."

STABILITY AND CHANGE IN HUMAN CHARACTERISTICS. Benjamin S. Bloom. John Wiley & Sons, New York. 1964. 237 pp. \$7.

The author, a professor of education at the University of Chicago, after examining a large mass of data from hundreds of longitudinal studies of the "shaping" of human beings from infancy to adulthood, concludes, among other findings, that change measurements are highly related to the environmental conditions in which individuals have lived during the change period; and that environmental variations have the greatest quantitative effect on a characteristic during that characteristic's most rapid change period, and the least effect during its least rapid change period.

In general, Professor Bloom's findings reveal the great importance of the first years of life for all the years that follow. "A central thesis of this work,"

he writes, "is that change in many human characteristics becomes more and more difficult as the characteristics become more fully developed. Although there may be some change in a particular characteristic at almost any point in the individual's history, the amount of change possible is a declining function as the characteristic becomes increasingly stabilized."

The purpose of the book, the author states, is to identify "stable characteristics," and to determine the conditions under which their stability may be modified.

SOCIAL WORK AND SOCIAL PROBLEMS. Edited by Nathan E. Cohen. National Association of Social Workers, 2 Park Avenue, New York, 10016. 1964. 391 pp. \$3.50.

The seven essays in this volume are the first fruits of a project of the National Association of Social Workers to define more clearly the contribution of social work to the solution of social problems. Developed on the basis of a

value-oriented model for analysis intended to emphasize the gaps between ideal objectives and actual operations, they focus on the following problems: poverty (by Norman Lourie); marital incompatibility (by Werner A. Lutz); child neglect (by Elizabeth G. Meier); deterioration of the inner city (by Lawrence K. Northwood); unmarried mothers (by Helen Harris Perlman); the broken family (by Otto Pollak); and racial discrimination (by Whitney M. Young, Jr.).

Each paper examines the values within in the community as well as within the social work profession which tend to deflect or fragment the profession's efforts to attack the problem under scrutiny. In the final chapter, the editor, in examining the usefulness of the model for analyzing social problems, points to the need for "new alignments" if the profession of social work is to raise its sights from its traditional clinical orientation to a concern for the "primary prevention" of social problems.

Guides and Reports

GUIDE FOR REFERRAL OF FAMILIES TO COMMUNITY HEALTH AND SOCIAL SERVICES. Department of Maternal and Child Health, Harvard School of Public Health, 55 Shattuck Street, Boston, Mass. 02115. 1965. 164 pp. \$3.15.

This guide, prepared primarily for use by a child health clinic staff in one city, identifies the interrelated health and social problems affecting the well-being of children and their parents, and outlines procedures for obtaining supplementary agency services needed by families with special problems.

WORLD OF PROMISE: A GUIDE TO THE UNITED NATIONS DECADE OF DEVELOPMENT. James Avery Joyce. Oceana Publications, Inc., Dobbs Ferry, N.Y.; and UNESCO Publications Center, 317 34th Street,

New York, 10016. 1965. 166 pp. Paperback, \$1.75 (UNESCO Publications Center); clothbound, \$3.50 (UNESCO or Oceana).

This illustrated guide describes the efforts of the United Nations and its affiliated agencies to mobilize both human and natural resources in underdeveloped countries, to develop skills to improve living conditions and realize national goals.

COMPENSATORY EDUCATION FOR CULTURAL DEPRIVATION. Benjamin S. Bloom, Allison Davis, and Robert Hess. Holt, Rinehart and Winston, Inc., New York. 1965. 179 pp. \$1.75.

A summary of the findings of the working papers contributed by participants in the Research Conference on

Education and Cultural Deprivation, held at the University of Chicago, June 8-12, 1964, with recommendations under three broad headings: national responsibilities, school-community responsibilities, and school responsibilities. Also included is an annotated bibliography on education and cultural deprivation, prepared by Susan B. Silverman.

DEVELOPMENT OF SELF-REPORT INSTRUMENTS IN DELINQUENCY RESEARCH: a conference report. Robert H. Hardt and George E. Bodine. Syracuse University Youth Development Center, 926 South Crouse Avenue, Syracuse, N.Y. 13210. 1965. 33 pp. \$1.

Summarizes the presentations and discussions of nine investigators' techniques for securing data on past delinquency-type behavior and activities from the persons involved, for analysis in determining the extent of such behavior and factors pertinent to prevention. An appendix includes samples of self-report questionnaires and interviews.

HERE AND THERE

Federal Legislation

New programs to improve the health of children and expansion of existing provisions for children are authorized under the 1965 amendments to the Social Security Act (Public Law 89-97), signed by the President on July 30. In addition to the widely publicized provisions for medical care for the aged and liberalized old age and survivors insurance benefits, the amendments authorize:

- A new 5-year program of special projects grants to State or local health agencies or schools of medicine and teaching hospitals to provide comprehensive health care and services for children of school age, or for preschool children, particularly in areas with concentrations of low-income families, including medical and dental screening, diagnosis, and preventive services for all children in the areas; and treatment, correction of defects, and aftercare, including dental care, for children of low-income families who would not otherwise receive such care; and appropriations for the program up to \$15 million for fiscal year 1966, \$35 million for 1967, \$40 million for 1968, \$45 million for 1969, and \$50 million for 1970.
- A new program of grants to institutions of higher learning for training professional personnel, such as physicians, psychologists, nurses, dentists, and social workers, for work with crippled children, particularly mentally retarded children and those with multiple handicaps.

- Appropriations for the new training program up to \$5 million for fiscal year 1967; \$10 million for 1968; and \$17.5 million for each fiscal year thereafter.

- Increased appropriations for grants to the States for (1) maternal and child health services, (2) crippled children's services, and (3) child welfare services; in each program up to \$45 million for fiscal year 1966; \$50 million for 1967; \$55 million each for 1968 and 1969; and \$60 million for succeeding fiscal years. After June 30, 1966, a satisfactory showing of progressive extension of

maternal and child health services and crippled children's services is required in the States, with a view to making these services available by July 1, 1975, to children in all parts of the State. A previous provision in the Act, earmarking child welfare services funds for day-care services, is no longer effective after January 1, 1966.

- Increases in the Federal share of public assistance payments, amounting, in the program of aid to families with dependent children (AFDC), to an average of \$1.25 per person a month; and exemptions in determining need for assistance of children's earnings up to \$50 a child (not to exceed \$150 per family) and of \$5 per recipient of any other income.

- A unified and expanded program of medical assistance to provide the same quantity and quality of medical assistance for dependent children and their families as to other recipients of public assistance, and, if the States elect, to any medically indigent child in need of medical care, as well as to adults who, while they do not meet the State's definition of financial need, are otherwise eligible for public assistance and cannot meet medical expenses.

The Anti-Poverty War

During the past summer, an increasing number of children and youth took part in programs established under the Economic Opportunity Act. (See *CHILDREN*, September-October 1964, p. 198, and March-April 1965, p. 81.) For example:

Project Head Start enrolled more than 550,000 preschool children from low-income families in centers in 2,400 urban and rural communities for 8-week programs to prepare them for entry to kindergarten or the first grade this fall. Focusing on developmental activities and preschool learning experiences, the projects also provided health and social services.

In addition to the children's parents, who in many instances were involved in the centers as teachers' aides, assistants in program planning, or workers in

a variety of nonprofessional jobs, some 45,000 people living in the neighborhoods of centers worked in them as "neighborhood residents."

Seventy percent of the Head Start programs were sponsored by local boards of education, the rest by private nonprofit groups, church groups, or community action programs functioning under the Economic Opportunity Act.

To provide special training for Project Head Start teachers, the National University Extension Association provided a series of 6-day training conferences on the campuses of 117 universities and colleges throughout the country. Some 35,000 teachers attended.

The Job Corps included over 10,000 young men and women from 16 through 21 in 48 Job Corps centers around the Nation as of the end of July. They were receiving basic and vocational instruction in 36 conservation centers, operated by the U.S. Departments of Agriculture and of the Interior, and in 7 urban centers for men and 5 for women, operated under contract by universities, business firms, and State agencies.

In addition, 54 more conservation centers and 10 more urban centers for men and 15 for women are scheduled to be in operation by July 1, 1966.

In the men's urban training centers, enrollees were being provided with training in such occupations as auto and appliance repair, small boat repair, cooking, retail sales, office work, and building maintenance. Enrollees in the women's centers were being taught clerical work, retail sales, cooking, household services, graphic arts, electronics, and child care.

A special corporation called Women in Community Service (WICS), formed by a group of religious and women's organizations, is recruiting and screening young women for these centers.

Neighborhood Youth Corps, as of July 30, included 346 individual projects providing jobs to 160,000 youths—in every State, the District of Columbia, and Puerto Rico; and in addition, 388 special summer projects, providing jobs for 125,000 young men and women.

VISTA volunteers, as of July 30, included 250 persons, ranging in age from 18 to 80, who were working in 59 anti-poverty programs in 27 States; and 800 others who were being prepared in 19

training programs to take over assignments in mid-August in nearly 100 local programs in 40 States. The assignments range from organizing and operating preschool and day-care centers for underprivileged children to helping communities and neighborhoods organize self-help programs. VISTA volunteers serve for 1 year on a subsistence allowance, and receive, on retirement from the program, an amount equivalent to \$50 for each month of service.

Under the college work-study program, as of the end of July, 38,500 students from low-income families were working on part-time or full-time jobs at a basic wage of \$1.25 an hour.

During the fiscal year ending June 30, 1965, the Welfare Administration approved 161 *work-experience and training projects* in 43 States, the District of Columbia, Puerto Rico, and the Virgin Islands, to improve the employability of approximately 88,000 persons with some 276,000 dependents, most of them children. By the end of July, about 21,000 persons had been enrolled.

The projects are training people as nurses' aides, hospital orderlies, child-care aides, maintenance workers in buildings and parks, and other occupations. All projects offer counseling, social service, medical care, and day care for children as needed.

Adoption

Findings related to the incidence of adopted children in caseloads of psychiatric clinics are contained in a recent study published by the Child Welfare League of America, "Behavioral Characteristics of Children Known to Psychiatric Outpatient Clinics," by Edgar F. Borgatta and David Fanshel. The study gives special attention to adoption status, sex, and age groupings.

The data are based upon information supplied by 30 agencies, geographically distributed, each having a minimum of a half-time social worker and a half-time psychiatrist or psychologist, and 607 cases were analyzed. In reference to some of the findings relating to adoption, the authors say:

"In summary, our study indicates that a higher agency arrival rate does exist for adopted children than might be expected for the general child population. The rate is possibly double, and certainly not as extraordinarily

excessive as was originally suggested by Schechter. If even relatively simple things, such as the selective factors of race, social class, and prior contact with agencies are taken into account, the apparent difference becomes of questionable significance."

The authors point out that, although findings with regard to severity of problems treated were not clearcut, they ran *contrary* to the notion that adopted children have more serious problems than nonadopted children, and favored the interpretation that adoptive parents tend to consult agencies when they see trouble ahead rather than after it has arrived—perhaps because they are adoptive parents, because they are familiar with agency help, or because on the whole they are in relatively high educational and occupational status.

The authors also point out that the findings cannot be generalized to all adopted, as compared with all non-adopted, children; but that they do indicate once again that when proper statistical controls are exercised—no solid support has been found so far for claims that adopted children are excessively prone to psychiatric problems.

Child Welfare Research

The function, planning, and conduct of demonstration projects in child welfare were the subjects of discussion at a 3-day workshop held at the University of Chicago last May, under the sponsorship of the university's School of Social Service Administration. Part of a project on evaluative designs in child welfare being carried on by the school with the support of the Children's Bureau, the workshop was attended by personnel from Federal granting agencies including the Children's Bureau, the Welfare Administration, and the Office of Education recipients of child welfare research grants, and consultants with experience in conducting child welfare demonstrations.

The conferees agreed that the primary function of a demonstration is the testing of feasibility and that any additional research aims included should be subordinated to this purpose. They stressed the importance of a pilot, or developmental, phase to a sound project. They also agreed that the results of every demonstration project should be disseminated to the child welfare field; that the attention of the field should be

called to negative results; and that replication, with appropriate modification under new conditions, is important in the accumulation of experience.

Eleven new child welfare research and demonstration grants totaling \$672,605 were awarded by the Children's Bureau between January 1 and July 1, 1965, along with \$1,581,251 for the continuance of ongoing child welfare research or demonstration projects. Of the new grants, three were concerned with child abuse and neglect. They went to:

- The Juvenile Protective Association of Chicago, \$97,420, to demonstrate the effectiveness of an integrated approach in the provision of the varied services needed by families in which children are abused or neglected.

- The School of Social Work, University of Pennsylvania, \$57,494, for a followup study of families which received intensive casework services from a protective agency.

- The School of Social Welfare, University of California, Berkeley, \$49,572, to initiate a series of studies of services offered by public welfare departments and other community resources on behalf of abused or neglected children.

Other new grants were awarded to:

- The District of Columbia Department of Public Welfare, \$145,066, for an expansion of services within its child welfare division to meet and prevent family crises.

- The Iowa Children's Home Society, Des Moines, \$74,493, to demonstrate a deliberate effort to reach unmarried pregnant teenage girls in rural areas with intensive services designed to help them achieve a constructive plan for the future.

- The American Humane Association, Denver, \$72,185, for a program to protect child victims of adult crimes from serious emotional damage.

- The Retarded Infants Services, Inc., New York, \$93,761, to conduct a 3-year project to test the feasibility of training and using unskilled personnel as aides to professionals in caring for retarded children.

- Western Reserve University, Cleveland, \$39,046, for designing long range research into the economics and organization of social welfare programs to find ways of analyzing "returns" in relation to "investments," criteria for evaluative studies, and means of trans-

lating the fruits of high-cost demonstrations to realistic large-scale application.

- The Children's Bureau of Delaware, \$38,730, for a study of adoption practices to determine factors predictive of success and of future crises.

- The University of Chicago, \$34,964, to explore the feasibility of establishing a center at the university to carry out child welfare research, demonstrations, and training.

- The University of Georgia, Athens, \$24,474, to develop a research program to determine effective processes for providing services in behalf of neglected children of low socioeconomic background in isolated rural areas.

Against Delinquency

Seven Federal grants were awarded between March and June of this year by the Office of Juvenile Delinquency and Youth Development in cooperation with the President's Committee on Juvenile Delinquency and Youth Crime. They included three *training grants* which went to:

- The National Council of Juvenile Court Judges, Chicago, \$18,898, to design and carry out a 2-week training institute, presented by an interdisciplinary faculty, for about 30 new juvenile court judges from courts serving rural and small urban areas, to serve as a model for universities and training centers in providing training opportunities for juvenile court judges.

- The Boston University Training Center in Youth Development, \$42,963, for a series of short-term workshops and institutes for probation officers, parole officers, public welfare personnel, and education counselors, to be carried out in cooperation with the appropriate State and local authorities.

- The Council on Social Work Education, New York, \$116,456, to design a comprehensive curriculum to prepare social workers for professional roles in community planning and action programs, to be based on a systemization of theoretical and research materials and on field studies of community organization practice, with the focus on professional intervention to achieve amelioration of social problems.

The other four grants, all *demonstration grants*, went to:

- The Hampton Beach Chamber of Commerce, Hampton, N.H., \$41,870, for a study by the Chamber's Teenage Relations Subcommittee of the psycho-

socioeconomic antecedents of youth riots at beach resorts, the development of strategies to control youth behavior at Hampton Beach during the 1965 Labor Day weekend, and the issuance of reports useful to other communities.

- Rutgers University, New Brunswick, N.J., \$89,732, for a program designed to help educationally disadvantaged children achieve social, emotional, and educational successes ordinarily not within the level of their expectations, through the provision of athletic, recreational, and vocational-experience programs; field trips; film-viewing; "book exposure;" lectures; tutoring (including tutoring of younger children by project participants).

- The Southern Arizona Mental Health Center, Tucson, \$63,659, for a program for early intervention in cases of identified potential delinquents and school dropouts in a sparsely populated, multi-ethnic area, through the use of significant individuals in the children's environment and nonprofessional, but specially trained, "mediators," and the operation of a motivation-and-skill training unit after school and on Saturdays, to help underachievers to improve their academic skills.

- The Active Community Team, Detroit, \$148,920, for the provision of a community intervention team at police precinct level, composed of professional, semiprofessional, and nonprofessional staff members, to which law violators 14 to 16 years old can be referred at time of police decision, and which will work within the neighborhood to provide these identified delinquents with appropriate service and opportunities.

UNICEF

The subject of family planning as a possible field for UNICEF (United Nations Children's Fund) was discussed for the first time by the agency's Executive Board at its June 1965 meeting in New York.

The U.S. delegation brought up the subject, placing it within the context of good maternal and child health services, and suggested that UNICEF's role might be that of training maternal and child health personnel in this field. The Board agreed to place the subject on the agenda for its next session and requested the agency's director to prepare a report on the scope and content of a proposed family planning program, after consultation with the World

Health Organization. The Board further requested that several family planning projects be brought to it for study from countries giving such aid a high priority in their requests to the agency.

The overall theme for the June meeting was "Reaching the Young Child." Papers and statements presented by both developed and developing countries indicated that the child from 1 to 6 is both neglected and hard to reach. No new UNICEF program was proposed, but the consensus of the meeting was that much greater effort could, and should, be made in all programs—health, nutrition, education, social services—to see that the needs of children in this vulnerable group are more fully met.

During the session, the Board committed nearly \$30 million to 200 projects in the fields of health services, disease control, nutrition, family and child welfare, education, and vocational training. The greatest increase was in aid to education, especially in Africa.

This meeting was the first under the leadership of Henry Labouisse, who became the organization's executive director following the recent death of the former director, Maurice Pate.

At the Board's next meeting, scheduled for May 1966 in Addis Ababa, Ethiopia, the needs of the African child will receive special attention.

Maternity Care

An "immediate, substantial, and concerted multidisciplinary attack on maternity care manpower shortages" is urgently needed, according to the findings of a study of the manpower situation in maternity care recently conducted by the Children's Bureau at the request of the Special Assistant to the President for Mental Retardation. In the study, the Bureau's Division of Research reviewed data on present and future needs for maternity care against the supply of health manpower in general and maternity care manpower in particular. The results suggest increasingly widened gaps between the need for and availability of the variety of health personnel used in maternity care.

Noting that today the infant mortality rate in the United States compares unfavorably with the rates in nine other countries and that, within this country, wide geographic variations exist in both

infant and maternal mortality with a tendency toward higher rates in rural areas and in the cores of large cities. The study related these differences to deficiencies in maternity care manpower in such areas. The improvement of present services and the provision of future services required by an increasing population of women of childbearing age, it found, will require:

- analysis of contemporary concepts of high-quality maternity care into its indispensable components;
- determination of which tasks might be assigned to auxiliary personnel of (a) types now in existence and (b) types which might be developed;
- development of fresh and effective service patterns to replace stereotypes of operation, in order to enhance quality of care and bring about more efficient use of manpower.

A chart book presenting the data and findings of the study will be published by the Bureau in the near future.

Rubella

By mid-July, 44 States had responded to requests from the Children's Bureau for information about the effects of the nationwide rubella epidemic which began in the East in the winter and spring of 1963-64, and spread to the South and finally to the Far West in 1964-65—the worst epidemic of this disease in the United States in two decades.

The survey was initiated by the Bureau in the spring of 1965 to determine the ability of the States to meet the needs of children adversely affected before birth because their mothers had contracted rubella while pregnant. According to an estimate of Dr. Richard Masland, Director of the National Institute of Neurological Diseases and Blindness, the epidemic resulted in "at least 4,000 defective babies born to the 2 million pregnant women then at risk."

Rubella, when contracted by the mother in early pregnancy, may result in such malformations in the offspring as hearing impairment, cataracts, anomalies of the heart, microcephaly, and mental retardation. The infant may also be born with active rubella infection and be the source of secondary cases of the disease.

Reports from the survey thus far indicate that a number of State health departments have instituted procedures to follow up the children born of rubella-infected mothers. For example, the

Kansas department, having from birth certificates a lead on rubella-connected disability, has instituted a followup study. California has appointed a full-time physician to follow up the cases of women who had rubella in early pregnancy. Other State health departments have alerted physicians or local health departments to watch for rubella-damaged infants. A number of medical centers are conducting special studies, by multidisciplinary teams, in the evaluation of rubella-damaged infants.

The Baylor University College of Medicine, Houston, Tex., has been granted \$70,314 by the Children's Bureau to maintain, for a 1-year period, a clinic for the multidisciplinary study and treatment of infants infected with rubella.

Public Health Service and industry scientists have recently developed a simple and rapid test for rubella, which provides identification of antibodies to this infection within 24 hours, as compared with the 2 weeks required for previous methods. Through use of the new test, the Public Health Service reports, timely reconnaissance can be made of any future rubella epidemics.

The Committee on Control of Infectious Diseases of the American Academy of Pediatrics recently issued a recommendation that "infants born with clinical features characteristic of intrauterine rubella infection be managed with the same isolation precautions employed for patients with rubella."

Health Research

In the first half of this calendar year, the Children's Bureau made 33 grants, totaling \$1,768,512, for new research projects in maternal and child health and crippled children's services, and 11 grants, totaling \$951,060, to continue projects already under way.

Included in the new projects are a number concerned with the reduction of premature births and maternal and infant deaths, reaching low-income groups with high-quality maternity and pediatric care, casefinding of children with potentially handicapping conditions, the efficacy of various treatment methods for handicapping conditions in children, and the reorganization of services to effect more efficient use of personnel and better quality of care.

Some of the award recipients were:

- The Johns Hopkins University School of Medicine, \$187,786, for the promotion and study of effective utilization of nonprofessional personnel in mental retardation centers.

- State University of New York, Downstate Medical Center, Brooklyn, \$91,066, to train and evaluate the use of "health visitors" recruited from disadvantaged neighborhoods to work in a housing project, a public school, a local union shop, and a small neighborhood.

- Harvard Medical School, \$107,795, to study the effects of providing comprehensive pediatric care to low-income families and children.

- California State Department of Public Health, \$72,275, for a study of children receiving treatment for congenital heart disease.

- The University of North Carolina, \$69,750, for a demonstration and research program in health needs and health care of children in a day-care center.

- The University of Chicago, \$21,414, for a controlled 10-year followup study of small (under 1,500 grams) premature babies.

Services for Health

As of mid-July, the Public Health Service had signed a contract with every State except Ohio and North Carolina, and with the District of Columbia and Puerto Rico, for counseling and referral services for Armed Forces medical rejectees, involving \$4,048,929 in Federal funds. The program began with three pilot projects established in New York City, Philadelphia, and Denver in 1962 following study and suggestions of a subcommittee of the Interdepartmental Committee on Children and Youth. (See *CHILDREN*, January-February 1962, p. 35, and January-February 1964, p. 34-35.)

Under the contract, a designated State agency will screen and evaluate Armed Forces examination station medical records of men rejected for military service for medical reasons; counsel the rejectees concerning their health needs; and refer them to health and rehabilitation resources for appropriate services.

The Vocational Rehabilitation Administration is collaborating with the PHS in the review and approval of implementation plans submitted by the States.

IN THE JOURNALS

Young Marriages

With the "long-term trend toward younger ages at marriage in the United States . . . now apparently arrested," programs to help youth "avoid injudicious marriage decisions" should concentrate on the development of the personalities, interests, and potentials of youth, rather than focus on the risks of youthful marriage, advises Lee G. Burchinal of the U.S. Office of Education, in the May 1965 issue of the quarterly *Journal of Marriage and the Family*. ("Trends and Prospects for Young Marriages in the United States.")

Defining "young marriage," as marriages involving at least one partner under 19, Dr. Burchinal reviews census data on the extent of such marriages from 1910 through 1960, and discusses some of the social factors which may be responsible for the stability of the trend since 1950.

He also discusses the meaning of data showing higher divorce and separation rates in younger marriages, as contrasted with marriages of persons in their twenties, warning that age is an adequate criterion for predicting marital risk only when accompanied by negative personality characteristics and interpersonal skills. Premarital pregnancy he names as probably the "single most compelling factor" leading to the erosion of young marriages, other significant factors being low-status background, limited education, meager economic basis, and the need for continued parental support.

Among the author's suggestions for reducing young marriage rates are: greatly increased educational, counseling, and social services; and the provision of "attractive alternate roles" for youth, through increased educational, service, and job opportunities.

"Project Books"

The Crawford County (Iowa) Department of Social Welfare's additional service of presenting books as gifts to children of underprivileged families in its caseload has "enabled us to estab-

lish wonderful relationships with the children," and "vividly illustrates to the parents . . . that we consider books important . . . as we do diet, health, or housing," says Dorothy B. Ferrell in the Spring 1965 issue of *Iowa Public Welfare in Action*. ("Books for Preschoolers.")

The author, a public welfare worker, uses brief case stories to describe the results of a project begun in November 1964, when a local business and professional women's club set up a fund for purchasing books to be given to the county's underprivileged children through its social welfare department. Later, other organizations joined in, reports the author, and collected used books for both preschool and older children, and the school library contributed women's magazines for distribution to the children's mothers.

Mental and Motor Test Scores

According to Nancy Bayley, writing in the June 1965 issue of *Child Development*, there is ample evidence that, within normal limits, developmental status in the first year of life is a poor predictor of later mental and motor functioning—and there is also ample evidence that mental test scores after 3 or 4 years of age bear a relationship to a number of indicators of socioeconomic status. ("Comparisons of Mental and Motor Test Scores for Ages 1-15 Months by Sex, Birth Order, Race, Geographical Location, and Education of Parents.")

The author, noting that the period between 1 and 4 years of age is important in the development of mental and motor functions, recommends that this age period be studied closely in efforts to seek out those environmental factors which are relevant to the development of intellect and of behavior seemingly resistant to environmental impacts; and to identify the behavior and the specific age periods for which correlation between test scores and socioeconomic ratings first occur. She also stresses the need for careful study of the devel-

opment of mental processes in the second year of life, as "within this period evidently will be found the explanation of the socioeconomic and ethnic differences in mental functioning that are repeatedly found for children of 4 years and older."

The author arrived at these conclusions after evaluation of tests in which revised forms of Bayley's scales of mental and motor development were administered to 1,409 infants, ages 1-15 months. The babies were drawn primarily from hospital well-baby clinics. No differences were found between Negro and white babies on the mental scale, but the Negro babies tended, consistently, to score above the white babies on the motor scale. The author suggests that the advantage the Negro babies have in motor development "may lie" in a generally heightened muscle tone.

Gang Control Controversy

Malcolm K. Klein, of the Youth Studies Center, University of Southern California, in the June 1965 issue of the quarterly *The Social Service Review*, discusses some of the major differences in assumptions held by the police and social agencies in New York City and Los Angeles which have led to controversies over the social agencies' use of "detached workers" in an effort to change the behavior of juvenile street gangs. ("Juvenile Gangs, Police, and Detached Workers: Controversies About Intervention.")

In these cities, detached worker programs were temporarily interrupted when the police charged that they created more trouble than they prevented. While in both instances the programs were continued under social agency-police agreement, the author points out that the agreements were "not . . . marked by any total resolution of value differences—nor should one expect such total resolution" when "two agencies can look at one set of data and, drawing 'diametrically opposite findings,' argue less over the facts involved than over 'philosophies of gang intervention.'"

Genuine resolution, the author suggests, requires empirical studies of the questions around which the controversies revolve, and he presents areas for inquiry under six (but "by no means all") of these questions:

Do "sponsored" gangs create more

trouble than "unsponsored" gangs? Does supervision of gangs lead to increased status? Does supervision lead to greater cohesion within the gang? Is gang leadership psychopathic? Are truce meetings between rival gangs helpful or harmful? Do gang workers increase anti-police feelings among gang members?

The author recommends that law enforcement officials and social work administrators come together and con-

sider dispassionately data that "are helpful in understanding the nature of the differences and in resolving the problems."

New Journal

Publication of a new quarterly, *The Journal of Applied Behavioral Science*, was begun in March by the National Training Laboratories of the National Education Association, with the stated purpose of seeking "to improve com-

munication between research workers in . . . anthropology, economics, political science, psychiatry, psychology, or sociology, and leaders in groups, organizations, and communities." The journal, according to its editor, Goodwin Watson, will focus on the processes by which individuals and institutions are changed, improvement of the research done in the behavioral sciences and facilitation of its application by influential practitioners.

READERS' EXCHANGE

BREWSTER: *Lessons for today*

Berta M. Brewster's article, "Extending the Range of Child Welfare Services" [CHILDREN, July-August 1965], reaffirms the thesis that with careful planning, sufficient competent staff, and coordination of resources, social services to children and their families can materially strengthen family life, reduce the need for foster care, and, even though expensive, provide the most economical means of salvaging young lives.

My concern is not with Miss Brewster's article nor the validity of the lessons to be learned from the pilot project in Rensselaer County. My concern is that these lessons were not learned in the early forties rather than in the mid-sixties. The lessons we should be learning today are not how to extend the range of services on a demonstration basis but how to make these vital and necessary services available to all children in our respective jurisdictions; how to provide the best services possible with less than optimum professionally trained staff; and how to finance and staff services statewide, reaching children in the most rural and professionally starved sections of the State, as well as those in the more urban and professionally stimulating environments.

In Mississippi, we have chosen the difficult approach of accepting responsibility for providing the full range of child welfare services statewide, realizing that the quality of service depends on the availability of staff and the competence of the staff serving children.

We, too, have learned many lessons. For one thing, children and families with serious child welfare problems live in every county of the State. As services become known in a community and the county department of public welfare is recognized as an agency responsible for protecting children and family life, referrals multiply and caseloads grow. We have found that even with an extensive program of educational leave it is not possible to retain staff in sufficient numbers to do more than maintain a status quo on geographic coverage with trained staff. We have found that agency-trained staff can attain an amazing degree of competence, if carefully selected and given the opportunity to develop under a supervisor trained and experienced in child welfare.

As a result of the lessons we have learned from our inability to extend quality service county by county, we are moving into a plan of trying to provide service on an area basis. An area office serves two or more counties and is staffed by a child welfare supervisor, at least one child welfare worker with professional training, and several agency-trained workers. From this plan we will gain experience in the differential use of staff, in identifying the situations in which agency-trained staff, with close supervision, can meet the needs of children. We will determine whether a worker, based in an adjoining county, can maintain a relationship with a child and his family which will enable him to diagnose problems and to be available when he is needed. We will evaluate the "holding power" of a group situation

where the workers have common goals, problems, and a sense of being a part of a team working toward the same objectives. We will find out whether the problems of coordination of area services with the other services for children in the local community are insurmountable or whether they can be worked out, with each component of service gaining in strength.

Sara R. Caldwell

*Director, Division of Child Welfare,
Mississippi State Department of
Public Welfare*

Colorado's way

The article by Berta M. Brewster is timely in pointing out the need for a variety of services to meet the needs of parents and children. The 1962 Public Welfare Amendments to the Social Security Act have made it necessary for all of us to scrutinize our program carefully to determine where primary emphasis should be placed.

Colorado, with a State-supervised, county-administered child welfare program, provides services to children in their own homes, including protective services. Some homemaker service has been provided since 1937, but so far in only 12 counties. Today, these have a total of 36 homemakers. Last year, 796 children were legally freed for adoption, their custody being given to county departments of public welfare with right to consent to adoption; and 725 children were placed in adoptive homes.

In this State we have long recognized the need for establishing a day-care program for children of working mothers, but now are seeing other uses for day care. In Colorado Springs, the county (El Paso) has established a center for children in the program of aid to families with dependent chil-

dren, who are referred because of neglect or abuse. Both children and mothers attend the center. While the children are engaged in planned activities, the mothers are taught how to be better mothers and homemakers.

In one of our rural, mountainous counties where a Catholic church donated space for a day-care center for culturally deprived children, numerous volunteers turned out to put the center in shape—a plumber to fix the toilets, others to cover the pipes with asbestos, to clean, and to paint. Tables and chairs were donated.

The 23 counties in Colorado having 91 percent of the State's population have 92 percent of the child welfare cases. However, we still have some rural counties in which there are no child welfare workers. In order to provide services to children in these counties, we plan to develop child welfare districts in which two or more counties will share a child welfare worker or workers. Salaries of these workers will be reimbursed by the State on 100-percent basis during the first year.

As of September 1965, there will be 45 public welfare staff on educational leave. Of this number, 17 will be going into child welfare.

*Marie C. Smith
Director, Division of Children and
Youth, Colorado State Department
of Public Welfare, Denver*

GLASSER AND NAVARRE: AFDC-connected problems

Aid to families with dependent children, our most significant program in its potential for strengthening family life, is at the same time the most maligned and misunderstood of the public assistance categories. Paul H. Glasser and Elizabeth L. Navarre, in the July-August 1965 issue of *CHILDREN*, emphasize the universal problem for all persons of low socioeconomic status and tell how this is heightened and intensified for the person living on a minimal AFDC grant. ["The Problems of Families in the AFDC Program."] More important, the study shows that the economic problems are compounded and aggravated by societal attitudes toward persons receiving AFDC. What emerges, then, is that all persons living in poverty have many complex problems, and when two additional factors are added—the least amount of money

and the attitude of our society because of the source of the funds—an unbearable burden is created for the families receiving AFDC. Added to this is the contradiction within society itself, in terms of what it expects of a woman who is the head of a family and how this further complicates the situation for the woman who must receive money from public funds.

All agencies which administer the AFDC program have ample evidence of how lonely these mothers are—how poignantly they feel society's attitude toward them and how this tends to alienate them from community living. In the administration of the program, they are referred to all too frequently as "AFDC mothers" or "mothers of AFDC children." Thus these mothers find that they are not only unwanted by society, but too often they feel that the agency, too, is not concerned.

Many communities provide special services to one-parent families created by death, divorce, or illness. All too often, however, these are not available for, nor do they accept, the lone parent trying to raise a family on an AFDC grant.

What illuminates this article is an empathy for the mother of the AFDC family, expressed in clear, uncomplicated, almost poetic language, indicative of the respect and warm regard the authors feel for these mothers. How essential this is, if they are to be helped to mobilize their own strengths and resources!

*Esther Lazarus
Director, Baltimore Department of
Public Welfare, Maryland*

POVERTY: Material wanted

A group of graduate students of the School of Social Work at the University of Toronto are planning, as part of their research project, a review of the North American literature on poverty.

We would like to enlist the help of professional colleagues in requesting copies of articles, speeches, pamphlets, booklets, unpublished papers, and other pertinent material dealing with all aspects of poverty in North America.

We hope eventually to publish an inventory of the literature on poverty, which will be helpful to many professional and nonprofessional sources. Please send copies of the available literature to the undersigned at the School of Social Work, University of Toronto,

273 Bloor Street West, Toronto 5, Canada. Your cooperation is appreciated.

*Benjamin Schlesinger
Assistant Professor, School of
Social Work, University of Toronto*

FANSHEL: More on Shared Fate

I have been interested in following the dialogue between David Fanshel and Arthur Glickman around Dr. Fanshel's review of David Kirk's "Shared Fate." [*CHILDREN*, September-October 1964 pp. 193-196; "Readers' Exchange, March-April 1965, pp. 87-88.] If the issue is still open, I would like to make the dialogue a triologue.

Personally, I welcomed Dr. Kirk's book not only for its own sake but because there are so few recent substantial studies into the nature of the adoption process. Moreover, it seems to me that in reporting on his research Dr. Kirk has gone beyond the technical. He has contributed the results of a long overlooked ratiocinative process which needs to be considered independently of the research method since it transcends any logical interpretation of experimental results.

Critical consideration of research ought to have an underlying philosophy which considers the process designed to test hypotheses separately from the kind of research designed to generate theories. I believe Dr. Fanshel was emphasizing the former; Dr. Kirk, the latter.

In the preparation of a competent research report, an important step is the attempt to view the data from a high-level of abstraction. No logical bridge exists between one level of abstraction and another. To take this step, a researcher must be more courageous and creative than in some other aspects of the reporting process.

My plea, then, is for an expanded style of research evaluation. Of course technical considerations should not be abandoned. But they should not become the totality of the reviewer's realm of operation. This should also include consideration of existing knowledge in the area being explored, the nature of the hypothesis-generating function of research, the translation in successive levels of abstraction, and most important, creative insight.

*Audrey Rawitscher
Doctoral Student, School of Social Work, University of Southern California, Los Angeles*

SOME U.S. GOVERNMENT PUBLICATIONS FOR PROFESSIONAL WORKERS

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**A SELECTED BIBLIOGRAPHY ON
DAY CARE SERVICES.** Alice H. Merriam. Department of Health, Education, and Welfare, Welfare Administration, Children's Bureau. 1965. 91 pp. Single copies available from the Bureau without charge.

The listings in this bibliography are presented in 16 categories including such subjects as administration, program, the parent, meeting special needs, planning and legislation, licensing and standards, research, and day care in other countries.

GRANTS-IN-AID AND OTHER FINANCIAL ASSISTANCE PROGRAMS ADMINISTERED BY THE U.S. DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE. 1964-65 Edition. Department of Health, Education, and Welfare, Office of the Assistant Secretary (for Legislation), Office of Program Analysis. 1965. 345 pp. plus fold-in tables. \$2.50.

This report provides facts on the backgrounds, purposes, financial as-

pects, application procedures, program developments, and legal basis of the 112 financial assistance programs under the Department of Health, Education, and Welfare. It contains detailed information on the formulas used in distributing funds, State matching requirements, and figures on funds allocated under each program.

COMPILATION OF THE SOCIAL SECURITY LAWS, INCLUDING THE SOCIAL SECURITY ACT, AS AMENDED, AND RELATED ENACTMENTS THROUGH DECEMBER 31, 1964. Compiled by the Department of Health, Education, and Welfare, Social Security Administration. House of Representatives Document No. 373 (88th Cong. 2d sess.), 1964. 677 pp. \$2 (paper cover).

In addition to the entire Social Security Act, as amended, the book includes sections entitled "Sections of Amending Acts Having Current Effect on the Social Security Act;" "Superseded Provisions of the Social Security Act;" "Provisions of the Internal Revenue

Code of 1954;" and "Selected Provisions of Other Laws Relating to the Social Security Act." Among the latter are sections of the act of 1962 creating the Children's Bureau, the Area Redevelopment Act of 1961, the Civil Rights Act of 1964, the Manpower Development and Training Act of 1962, and the Peace Corps Act.

HEALTH SERVICES FOR UNMARRIED MOTHERS. Elizabeth Herzog and Rose Bernstein. Department of Health, Education, and Welfare, Welfare Administration, Children's Bureau. CB Publication No. 425. 1964. 61 pp. 25 cents.

Reviews studies relating to complications of pregnancy in unmarried mothers; availability, use, and quality of medical services available to them; and experiments to bring them coordinated medical and social services. The strengths and weaknesses of the studies and the generalizations derived from them are evaluated, and areas for future studies suggested.

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NOVEMBER • DECEMBER 1965

AN INTERDISCIPLINARY JOURNAL FOR THE PROFESSIONS SERVING CHILDREN

**This Most Profound Challenge
Invisible Rights of the Poor
Siblings of the Retarded
Parental Control and Love**





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A WANTED CHILD means fulfillment for the mother expressed in the kind of loving care which nurtures a child's potentials for healthy development. A succession of unwanted children may mean poverty and despair for the parents, blighting their nurturing abil-

ties to the detriment of the entire family. This realization and the challenge of a progressively accelerating population growth are behind the growing support of family planning services which is described in the opening article in this issue.

Justine Wise Polier has been a judge in the New York State Family Court and its predecessor court, the Domestic Relations Court of New York City, since 1935. She is also president of Witwyck School for Boys, a residential treatment center for emotionally disturbed children, and of Louise Wise Services, a voluntary adoption agency in New York City; a board member of the Foster Care Commission of New York City and the New York School for Nursery Years; and a member of the executive committee of the Citizens' Committee for Children of New York.

Since administering the project he and Mary Feeley describe in this issue, Meyer Schreiber has joined the staff of the Children's Bureau as consultant on social services to mentally retarded children, with headquarters in the New York regional office. Miss Feeley has returned from educational leave to the Bureau of Child Welfare, New York City Department of Welfare, and is now its chief of community relations and public relations.

Jane O'Neill, a graduate of the School of Social Service, Catholic University of America, has worked in public and private social agencies directly with families and children, including children in foster care, and as a supervisor of public assistance and child welfare workers. The project she describes in this issue was conducted by the maternal and child health section, Connecticut State Department of Health, with support from the Children's Bureau.

Diana Baumrind, since receiving her Ph. D. from the University of California in 1955, has been a staff psychologist at the Cowell Hospital in Berkeley; director of two U.S. Public Health Service research projects at the university concerned with the assessment of the effectiveness of psychotherapy and of child training; and consultant to a California State project on emotionally disturbed children in Redwood City. From 1958 to 1960, she was in private practice in Berkeley.

A social worker and educator, Ivor Kraft came to the Children's Bureau in 1962 from the Children's Guild in Baltimore, Md. He has worked as a school social worker and with family counseling agencies and has taught courses in child development at the college and university level. In 1964, Dr. Kraft led a group of social workers on a study tour of the Soviet Union and other countries of Eastern Europe.



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THIS MOST PROFOUND CHALLENGE

KATHERINE B. OETTINGER

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IN HIS STATE of the Union message last January, President Lyndon B. Johnson said, "I will seek new ways to use our knowledge to help deal with the explosion in the world population and the growing scarcity in world resources." Recently, he has been even more specific in asking the Nation to "face forthrightly the multiplying problems of our multiplying populations and seek the answers to this most profound challenge to the future of the world."

In the same vein, former President Eisenhower recently stated: "If we now ignore the plight of those unborn generations which, because of our unreadiness to take corrective action in controlling population growth, will be denied any expectations beyond abject poverty and suffering, then history will rightly condemn us."

These statements have come at a time when a rising chorus of voices from all segments of our society has been calling for national attention to the problem of a population growth and its allied problems of health and welfare. It has included a series of policy expressions from powerful national groups. For example, late last year, the trustees of the American Medical Association urged the association to cooperate with nonprofessional groups which had "adequate medical direction" in dispensing information about family planning. They asserted:

An intelligent recognition of the problems that relate to human reproduction, including the need for population con-

trol, is more than a matter of responsible parenthood; it is a matter of responsible medical practice.

Last year the American Public Health Association urged that—

Federal, State, and local governments in the United States include family planning as an integral part of their health programs, make sufficient funds and personnel available for this purpose, and insure such freedom of choice of methods that persons of all faiths have equal opportunities to exercise their choice in accordance with their conscientious beliefs.

In 1962, the National Association of Social Workers called for attention to the need for family planning services.

In 1964, the American Public Welfare Association's board of directors, stressing the "importance of family planning to assist families to attain the highest potential," urged that welfare clients be referred for this kind of assistance if they requested it.

Last spring, the National Academy of Sciences, National Research Council, in reporting on the growth of the U.S. population, stated:

The freedom to limit family size to the number of children wanted when they are wanted is, in our view, a basic human right. . . . Most Americans of higher income and better education exercise this right as a matter of course, but . . . many of the poor and uneducated are in effect deprived of the right. No family should be fated through poverty or ignorance to have children they do not want and cannot properly care for.

The continuing thread running through this dialogue has been respect for the conscience of individuals to determine freely if they wish to space their families by methods morally acceptable to them.

Based on a paper presented at the Fall Conference on Public Family Planning Clinics, New York, September 9, 1965.

Let us look at the current role of the Federal Government in meeting "this most profound challenge to the future of the world."

Secretary of the Interior Stewart L. Udall has announced a program to make contraceptive advice and services available, when desired, to American Indians, Eskimos, and natives of the islands the United States holds in trust in the Pacific.

The Office of Economic Opportunity will approve Federal funding for family planning services under its community action programs, if the community wishes to undertake that activity. This program is just getting under way, so there is no way yet to know how many communities will do so.

The U.S. Department of Health, Education, and Welfare is carrying forward the three program elements—research, training, and service—which are essential for illuminating the nature of population changes, for providing new and better methods of controlling fertility, and for investigating the social and psychological aspects of family planning.

For example, its National Institute of Child Health and Human Development supports basic research in reproductive biology which will lead to better understanding of those factors which lend themselves to the creation and development of healthy, new human beings. It is currently spending about \$500,000 a year to support research directly related to population problems.

Most recently, the Institute awarded a grant to Princeton University to survey birth control practices. This study, the first since oral contraceptives came on the market, will provide a base for other studies of the influence of birth control practices on the health of women and children. One interesting aspect is that it will provide data on the size of the family desired by parents.

The Children's Bureau, as a part of its program-related research, is making research and demonstration grants on various phases of family planning. For example, to get at the complexities surrounding the question of motivation for family planning, the Bureau has awarded a grant to the Community and Family Study Center in Chicago to inquire into two basic questions:

1. Why do some low-income families totally reject family planning, or accept it only on a limited or temporary basis?

2. How do prevailing community attitudes and the individual's own psychology work to promote or impede the adoption of birth control measures?

Another Children's Bureau grant has gone to the Hudson Institute in New York State, which will project what the U.S. birth rates might be in 1975 as a basis for developing alternative plans for future maternal and child health services according to the country's requirements.

A third grant has gone to the Tulane University School of Medicine, New Orleans, to continue its study of fertility and attitudes relevant to fertility and family planning among a group of 1,000 mothers in the New Orleans area.

Personnel Training

President Johnson has pointed out that "in all sectors of health care, the need for trained personnel continues to outstrip the supply."

Many parts of DHEW are, in fact, supporting grants, institutes, fellowships, and other means of augmenting our supply of trained health personnel.

For example, in the maternal and child health and crippled children's programs administered by the Children's Bureau, practically all the States are using some of their Federal funds to provide special training opportunities to physicians, nurses, nutritionists, medical social workers, and other professional personnel. Most maternal and child health programs in schools of public health which these trainees attend now have family planning in their programs, but more concentration on this aspect of public health is needed in teaching hospitals.

In a few State maternal and child health programs, inservice training is going forward to supplement a pool of physicians able to give medical consultation on up-to-date methods of contraceptive technique. One of the paramount uses of this pool of technicians is to provide consultation to counties who want to upgrade their programs. In a very efficient way, this method gives all physicians in a given community the opportunity to take advantage of the most advanced medical knowledge in this area. If this form of inservice training were extended on a national basis, the benefit could be immeasurable.

The Children's Bureau is also directly supporting programs for training professional men and women specifically geared to the roles which various disciplines must play to effectively develop family planning programs. For example, this fall we are offering a 4-week course to about a dozen registered nurses from various parts of this country to study family planning at the Graduate School of Nursing of the New York Medical College. This course, to be given concurrently with a training program for

nurses from other countries, sponsored by the Agency for International Development and the Children's Bureau, will enable both groups of nurses to participate in classroom and clinical experience, including study of the use of specific contraceptive devices.

Support of Services

The Children's Bureau is in a key position in the involvement of the U.S. Department of Health, Education, and Welfare in helping to support family planning service programs. Our basic concern has always been, and always will be, to improve the social and physical health of mothers and children throughout the country. Our obligation under the Social Security Act is to assist the States in promoting these health services.

In recent years, a marked change in attitudes toward family planning and improvements in the various methods that can be offered have made it possible for States, many of which already provided family planning services as an integral part of their maternal and child health programs, to expand such services and for other States to initiate them.

This expansion could not have occurred without the unstinting efforts of voluntary organizations in sponsoring demonstrations of family planning services. These pioneers have always maintained high standards, a valid scientific approach, and excellent interpretation about the true meaning of family planning as a part of responsible parenthood.

Research foundations have poured millions into studies focused on family planning, and pharmaceutical firms have made an immense contribution by developing resource material and training tools.

However, the numbers of families seeking such service and the vast urban and rural areas to be covered exceed the services voluntary efforts can supply. Moreover, the conviction has grown that education and instruction in effective family planning should be included as components of the programs of the health and welfare agencies responsible for the payment of health services for dependent families. Too many parents among the poor have suffered spiritual dejection and demoralization after bringing more babies into the world than they can provide for in a way that will develop the children's potential or help them break the cycle of poverty.

Federal matching funds are available for medical services connected with family planning under the public assistance titles of the Social Security Act. These may include physicians' services, clinical and hospital services, prescriptions for drugs and devices,

and other preventative and rehabilitative services associated with a comprehensive program for family planning.

Further impetus for expanded activities came with the enactment in 1963 of the maternal and child health and mental retardation planning amendments to the Social Security Act, which authorize a new program, administered by the Children's Bureau, of special projects for maternity care for women in low-income families—projects intended primarily to reduce the incidence of mental retardation due to prematurity and complications of pregnancy.^{1,2} Most of the States and localities which have chosen to take advantage of this maternity and infant care program have included family planning as a part of their comprehensive care.

During fiscal year 1965, 27 States spent an estimated \$1,835,000 for family planning services in relation to maternal health programs. State plans submitted to the Children's Bureau for the current fiscal year show that some States are planning to double their expenditures for family planning services in their programs of maternity and infant care.

Experience so far in these projects indicates that the institution of family planning services more than doubles attendance at post-partum clinics and, in some projects at least, seems to have a favorable influence in attracting women to prenatal clinics early, as word gets around that the services are available. For example, in Augusta, Ga., over 85 percent of the women delivered in a maternity and infant care program for women of rural counties have returned for the critical post-partum examination and 90 percent of these have asked for family planning advice.

The Children's Bureau has just added a staff member to obtain further factual information about family planning services provided by State and local health departments. Her findings are expected to enrich future program planning in this field. Beginning with the current fiscal year, we are asking the States to give us basic information about the numbers of persons receiving family planning services. This will indicate the scope of services and where additional new approaches may be needed.

The Concept of Service

It should be quite clear that the definition of family planning is not limited to the *spacing* of children but also includes a concept of service to couples who seek to correct infertility in order to have a family. As a part of this definition, it is a goal—but certainly not a reality—to have family planning services avail-

able in communities, not just as a part of the post-partum clinic service, but as a part of regular maternal services which women could use at other times than during the maternity cycle. There is a beginning in this direction—but only a beginning.

We are aware that we are still at the beginning of a learning experience, but early evidence indicates we will come to know much more about the physical aspects of family planning, the usefulness of the devices themselves, people's attitudes toward their use, and the continuity of interest in this subject.

Most importantly, we need to know how to communicate with families so that they internally accept family planning as a part of their family pattern. And when we speak of families, we are talking about *both* parents—the base of family life. Our efforts will be both futile and misdirected if we fail to involve the husband and father in family planning. It now is being done to some extent in the maternal care programs but greater progress needs to be made in this direction.

I can think of no more concrete example of the need for the involvement of both parents than a letter written to a staff member of the Children's Bureau.

"Dear Sir," the letter began, "I am writing to ask your advice. I want some personal advice and not just some little papers or pamphlets."

The writer went on to say that at the times his wife gave birth to their first two children she had gotten up in a day or two and begun helping him in the fields. Then he related what happened to her in each successive pregnancy—her third, fourth, and fifth; her sixth ended in a miscarriage. By the end of the first page she had had nine pregnancies. In her 10th, she had had a convulsion, then followed her 11th, 12th, and 13th. And now she was pregnant for the 14th time. She did not want to do anything except lay around all the time. He did not know whether she was getting lazy or not. He had heard that when women had grown children they liked to sit down and let their children wait on them.

The letter ended with the question, "Can it be that my faithful wife don't want to help me anymore?"

Social Needs

Many men who father children with every intention of giving them adequate care become so overwhelmed at the economic burden which each successive child brings them that in time their adequacy as a family head fails. Too often the family itself becomes a casualty. Even fathers who take "moonlight" jobs often cannot make ends meet. Despite

the principle so long advanced in the child welfare field that no child shall be separated from his family for economic reasons only, children often wind up in public institutions, seriously dislocated from the society of which they must some day be a part.

Social workers are confronted daily with situations in families which force them to search for palliatives rather than real solutions to problems. For example in the first 9 months of 1964, in New York City alone there were 443 well babies left in hospitals by mothers who simply walked out because they had no way of caring for them. When emergency placement measures are undertaken to clear the hospital beds they occupy so that others can be served, these young infants too frequently spend their growing years in so-called "temporary" shelters.

The enormous impact of this problem is reflected in many ways in the child welfare services program. In a recent year, 36 percent of all children receiving services by public child welfare agencies were children neglected by their parents.

In administering both maternal and child health and child welfare programs, the Children's Bureau is acutely aware of the problems of young unmarried mothers. We feel a special obligation to see to it that they get every help they need, for we have proof that their children are frequently more susceptible than others to physical impairments, as well as to social and emotional handicaps.

Healthy mothers and babies are a paramount part of our national concern for the future well-being of all our citizens. We are, of course, greatly concerned that we have only the 10th lowest infant mortality rate among the leading nations of the world. President Johnson has called for a drastic reduction in this rate by the end of this decade. Could it be mere coincidence that in all but one of the nine nations which now rank ahead of us, the birth rate is also lower than in the United States?

Many of us are working together at a new rapid pace as the dimensions of our problem become clearer for reaching the goal of providing better health for the mothers and children of this Nation. If family planning is a useful tool in achieving this goal, then it should be available on a universal basis as a *right* of parents, without coercion, but with genuine and sympathetic attention to the needs of each human being.

¹ Lesser, Arthur J.: Accent on prevention through improved service. *Children*, January–February 1964.

² Close, Kathryn: Giving babies a healthy start in life. *Children*, September–October 1965.

Do children have legal rights? If so, what are they and how can they be protected? Various aspects of these important questions are to be discussed in a series of articles in this journal. It begins here with some views of a family court judge, presented at the National Conference on Law and Poverty in Washington, D.C., last June, on problems of families and children involving . . .

THE INVISIBLE LEGAL RIGHTS OF THE POOR

JUSTINE WISE POLIER

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AHIERARCHY in law reform has been permitted to develop in this country. Until recently reforms in civil law affecting property rights have been at the apex,¹ and reforms of criminal justice have held second place.² Far below, at the base of the pyramid, we find civil law reforms as they affect the daily lives of the poor, whose legal rights have remained largely invisible to the bench, the bar, and the community.

Juvenile and Family Courts

Juvenile or family courts have now been established in every State. These courts, while hailed on special occasions as essential to strengthening family life, have been treated as low man on the judicial totem pole, not requiring legal acumen, and have been starved for necessary administrative, judicial, and service personnel.

A recent study of judges in the juvenile courts has revealed that nearly a fourth were not licensed lawyers, and that they lacked "the basic professional credentials deemed essential to preside over any court."³ In answer to a questionnaire, 33 percent of the full-time juvenile court judges who reported stated that they did not have any probation officers

or social workers in their courts. For rural courts, the comparable figure was 54 percent. Eighty-three percent of the judges who reported stated that they did not have the help of any psychologists or psychiatrists. The study concluded:

... the profile of the juvenile court judge and his work . . . offers an image of a part-time judiciary, large components of which do not have adequate professional preparation or opportunity for in-service training and which operate under difficult caseloads and without adequate resources to properly discharge their assigned responsibilities. . . .⁴

This profile, drawn 65 years after the creation of the first juvenile court in Illinois, reflects six decades of failing to come to grips with the needs of poor children and families in an increasingly complex society. It also illustrates the danger inherent in the creation of a legal institution when the legal profession fails to take active and continuing responsibility for its development.

The jurisdiction of our juvenile courts has been steadily enlarged to encompass not only delinquency but also child neglect and a wide range of family problems. However, the enlargement of jurisdiction has not been accompanied by the provision of the kind of personnel or services essential to provid-

ing the constructive help which is authorized by the statutes.

Contrary to what one might reasonably expect, services for the care and rehabilitation of delinquent children have been more nearly adequate (at least in quantity) than those for dependent and neglected children.⁴ In New York City, the discrepancy in facilities and services for neglected and delinquent children was so great in 1963 that although 60 percent of the children brought before the court initially were alleged to be delinquent, 65 percent still awaiting disposition after 3 months were children brought to the court because of neglect.

For many thousands of children, the gap between legislative purpose and judicial action spells a substantial denial of legal rights that demands reform far beyond the assurance of a fair trial. No court should be permitted to serve as a container for troubled children and their families or as a curtain to conceal their problems. The juvenile court should be one of many agencies to break through walls of poverty, to discover the individual child within his family setting, and to apply the skills of our society to help each to find his proper place in our world. This it has failed to do.

Violation of Rights

The use of a legal aid society or an assigned counsel to represent children is a first step toward correcting the violation of legal rights. It does not, however, touch the pervasive denial of legal rights which children and poor families are all too often unaware of and which they are unable to assert. To mention only a few:

1. Transfer to prisons without the protections guaranteed under the criminal law.

In over half the States, in the District of Columbia, and the Federal system, children who have been removed from their homes through the informal non-criminal process of the juvenile court may end up in jails, reformatories, or penitentiaries established for persons convicted of crimes. Many of these children have not committed acts which would be crimes if committed by adults. It has been estimated that between 500 and 1,000 young people are in penal institutions today who have neither been charged with nor convicted of any crime. Forty-seven of 141 State training schools located in 22 jurisdictions have statutory authority to transfer children to penal institutions without referring them back to court.⁵ In some jurisdictions, such action can be taken against chil-

dren upon whom the only judicial finding has been one of neglect.

2. Unequal justice for the unmarried mother and her child.

There is an urgent necessity for facing the legal and social problems of the more than 200,000 children born out of wedlock each year and their mothers.

In 1960, the State of Louisiana denied previously granted assistance to over 20,000 children in families with a child born out of wedlock on the ground that their homes were "not suitable." No alternative provision for their food, clothing, or care was made. However, after a formal hearing in which *amicus curiae* briefs were filed by Orison Marden on behalf of the Family Service Association of America, by Shad Polier on behalf of the Child Welfare League of America, by Lyle Carter on behalf of the National Urban League, and others, the Secretary of Health, Education, and Welfare issued a ruling that forced an end to such blatant injustice.⁶

However, less obvious but as wholesale denials continued elsewhere. Shortly after the Louisiana ruling, I asked a citizen of a neighboring State how his State was meeting the increasing need for assistance to children born out of wedlock. He answered that the problem was not too serious because unmarried Negro mothers did not dare apply.

The denial of equal justice to unmarried mothers and their children takes different forms in the large urban areas of the North. Access to birth control information has been denied those who are poor because of policies of public hospitals and departments of welfare. Also, although many maternity homes have recently begun to accept Negro applicants, equal access to residential care is by and large still not available to nonwhite pregnant girls. And a far higher proportion of nonwhite girls than white girls are brought to court as delinquents because of out-of-wedlock pregnancy.

A white girl "in trouble" is usually advised that she may surrender her child for adoption and start life anew. This she usually does. In contrast, a nonwhite girl is likely to be told that a surrender will not be accepted unless a family is found who will adopt her child, and she must therefore continue to be held financially responsible for her child. For most nonwhite girls, the choice is to leave her infant in a shelter for months pending some uncertain placement plan, to take the child (wanted or unwanted) back to the family home, or to abandon the child and disappear. While many unmarried Negro mothers

apparently do wish to keep their children, those who do not wish to do so often have no other choice.

The American Indian child presents another example of inadequate services. Although in many Indian communities there is a strong tradition of keeping a child born out of wedlock in the family, in many instances a child may have no home, be obliged to live in a home where he is not wanted, or be placed in foster care at an early age. The possibilities of adoption are limited by insufficient resources and the complicated legal and jurisdictional problems existing on many Indian reservations. However, in recent years, some adoption opportunities for Indian children have been opened through a special project sponsored by the Bureau of Indian Affairs, U.S. Department of the Interior, and the Child Welfare League of America, whereby Indian children are placed for adoption with both Indian and non-Indian families in various parts of the country through some local adoption agencies. Thus the wall of prejudice that so long has separated the Indian child from the rest of the American community is being pierced.

While the old concept that children must be matched if they are to be accepted by their adoptive parents is no longer accepted by most adoption agencies, we still find official opposition in public departments and courts to placing children across racial or religious lines, even when it is clear that without such a placement they will never belong to anybody.

The extent to which race prejudice has been woven into the adoption practices of this country and the denial of legal rights have been institutionalized will require years of concerted thought and action to correct.

3. Termination of parental rights—orphans with parents.

In the words of Konrad Lorenz:

Birds reared in isolation from their own kind do not generally know which species they belong to.

No text could provide a more accurate description of the many "orphans" with parents who are placed for indefinite periods in children's institutions or a succession of foster homes. These are the unwanted children forgotten by their parents, who nevertheless maintain legal ties with them.

The termination of parental rights raises thorny questions that reflect conflicting views about the "natural rights" of parents, the rights of the child, the child's best interest, and the duty of society to inter-



A child of poverty. Protecting his legal rights and those of his parents may help him find pathways to a better future.

vene in order to protect the welfare of the child. Social agencies, welfare departments, and courts tend to procrastinate when faced with this problem, even though inaction spells denial of normal family life for a child. In 1955, a self-survey by 14 child-caring agencies responsible for 17,000 children reported that, for 1 out of 5 children then in long-term care, adoption would have been a sound plan if it had not been overlooked.⁷

In New York State, legislation was enacted in 1955 and in 1959 to authorize social agencies, after seeking and failing to induce the natural family to make reasonable plans for the child's return home, to have the child in long-term foster care declared permanently neglected and so freed for adoption. In 1962, this concept was incorporated by law into the policies of the new statewide family court, which was given original jurisdiction in proceedings "to permanently terminate the custody of a child where there is permanent neglect." However, almost no cases of this kind have been brought before the court by either public or private social agencies.

Such inaction also reflects the primitive ideas that are still all too prevalent in regard to the responsibility for poor children who are placed in foster care. Dependent and neglected children wait in shelters for months and years after a judicial finding that foster home care or adoptive care is indicated. Too often, in my experience, they have been offered to

agency after agency like pieces of unseen merchandise, with crude identifying data as to birth, sex, age, religion, and color. Some children—usually those most desperately in need of individual, loving care—see many others come and go while they remain in the shelter. There is generally no one to represent such children in legal action against the public departments responsible for providing them with appropriate care.

When cases are taken to court, too many social agencies assume that since they are trying to do what is right, the judge can and should follow their recommendations regardless of the rules of law. If progress in legislation is to become meaningful in the lives of poor children, responsible social agencies will have to secure the aid of competent counsel both for court appearance and consultation. Social agencies would never go into court without the aid of competent counsel in actions involving a bequest to the agency or the recovery of property. Surely it is not too much to expect equal concern for legal competence when the life of a child is involved.

4. The inverse ratio of payments to real benefits.

Surely it is inconsistent with our grave reluctance to sever parental rights, and our practically unanimous agreement on the need to strengthen family life, that in this affluent country mothers in the aid to families with dependent children (AFDC) program receive on the average less than \$1 a day for each child. If we find that the home is inadequate, that the mother is unable to cope with the problems of so many children, we remove the child to the home of a stranger or series of strangers, paying from public funds up to \$7 a day for the child's care. If the child is removed to an institution, the institution is paid up to \$14 a day. Finally, if the child becomes emotionally disturbed, payments from public funds may range from \$10 to \$25 a day. Thus, the further the child is removed from his family, the more we are ready to pay for his support. Only the Mad Hatter could explain this.

Underlying Problems

The children I have referred to so far represent only a small segment of the poor. They are the troubled children someone has noticed, or the children who have become troublesome to the community after having been left unnoticed and unhelped for many years.

Though they are numbered in the tens of thousands, they are only a segment of the millions of chil-

dren who are growing up in dire poverty. This country is now seeking ways to help these children escape from poverty. I would submit that this will require provision by law of an adequate standard of income for children in their own families—a standard sufficient to provide adequate nutrition, clothing, schooling, medical care, and a sense of belonging to, and being a prized member of, our society.

According to recent studies, 15 million children live in families where everyday living requires choosing between an adequate diet of the most economical sort and some other necessity.⁸ For these children such poverty also means overcrowded, inadequate housing—for 4 million of them, housing which endangers their health or safety. One-third of them live in families without fathers.

Poor families must also scrimp on clothing, recreation, personal care. Without access to credit, they pay more for insurance, for purchases made on time, for money borrowed, and for almost every purchase made. They usually live in areas where all public services, from schools to garbage collection, are most inadequate.

We do have our "income maintenance" programs, the social insurance and public assistance programs provided for under the Social Security Act, and, in some places, general relief programs for indigent families who do not fall into the Social Security Act's specified categories. But the size of benefits and payments under these programs are, for the most part, notoriously inadequate for meeting the families' needs. For example, a recent study has shown that the total annual income from all sources in families in the AFDC program, excluding payments for medical care, averaged \$1,680 per family.⁹

Then, there are the problems created by the ways in which the assistance programs are administered. They have been too largely shaped by characteristics derived from both the Elizabethan Poor Laws and traditional charity.

True, certain basic principles to protect the recipients of assistance have been incorporated as conditions of Federal reimbursement to the States. These include equitable, prompt treatment without discrimination to all people in like circumstances of need, and the administration of assistance in such a way as to protect the dignity and self-respect of the people served. The enforcement of these principles at State and local levels would do much to alleviate the problems of "poor" children and families throughout this country. Unfortunately, too few members of the legal profession are aware of the

extent to which these principles are being violated.

Of all minority groups, families who are poor are the least able to assert, or even know about, their rights. Composed in large part of fatherless families or of families in which the father is unable to live up to the expected role of providing support, they are defenseless and lacking in hope.

While we have increasingly recognized through law the necessity for providing subsistence rations to such families, we have largely failed to provide those services or methods of help essential to self-respect and hope. We have developed vast administrative structures to screen and rescreen families for their eligibility for the pittance to which they are entitled. We have assumed that in receiving a tax-supported grant a family gives up the right to privacy in the home, the manner of expenditures, a TV or a telephone, and its own standards of moral conduct.

We have at times self-righteously ordered out of a home a man who could not marry because a divorce was beyond his means, even if one of the children was his own. At other times, we have told the woman that unless the man who visits but cannot marry her moves into the home and helps support the family, the assistance grant will end. We have demanded that families receiving assistance account for the earnings of their adolescent and adult children in a way that no middle-class family would dare to demand of its own children. We have fostered deception and provoked young people to move out of the home into furnished rooms so as to avoid the demands of the welfare agency.

At the same time, we have been slow to remove children known to be seriously neglected from their homes since costs in foster-care facilities are high and the facilities and services are inadequate.

All of us have taken part in a series of self-deceptions and pretensions out of ignorance or a need to conceal what we were doing and not doing for and to poor families. We speak constantly of the "social workers" who administer public assistance, but no more than 4 percent of such public assistance personnel is professionally trained. True, this situation rises partly from the dearth of professionally trained personnel. But it also reflects the all too common attitude that anyone can investigate poor people and tell them what they are to do or what they may have. Moreover, the overwhelming size of caseloads in many public welfare agencies, the emphasis on eligibility determination and discovery of "fraud," and the amount of clerical work involved deter young people

from entering the public welfare field in spite of its crying need for dedicated and professionally trained men and women. Happily, increased Federal fund matching for administrative purposes is now encouraging the reduction of caseloads, the provision of public welfare services, and higher educational standards for beginning workers.

Protection of Rights

The goal of a "great society" demands a far greater concern for the welfare and potential of the individual than is prevalent today. The complexities of administration and the conflicting interests of many of those who administer "government largesse" have been a source of restriction to the individual recipient of benefits.¹⁰ The extent to which the methods of granting government benefits enlarge or decrease the individual's capacity for living fully is a challenge to law—in its lawmaking, administrative, and judicial functions, and in the evolution of law as a social institution.¹¹

As long as government at any level is regarded as an agency of charity, it is likely to exercise its vast use of the tax dollar with the carrot-and-stick philosophy of old-fashion charity for the "deserving poor"—and in the demeaning manner characteristic of the middleman who transmitted favors from the rich to the poor—unless the administrative and judicial arms of the law challenge such undermining of rights created by law.¹² The legal profession can bring this about by uncovering violations of the rights or entitlements of the poor, and by exploring new methods and procedures to protect the rights of individuals entitled to assistance and to a wide range of services.

The violations of the rights of the poor have taken many forms which we are only beginning to recognize. In 1963, Professor Reich of Yale wrote an incisive constitutional challenge to the practice of sending unannounced welfare investigators to the homes of relief recipients at all hours.¹³ And Elizabeth Wickenden recently prepared a list of constitutional issues affecting applicants and recipients of assistance.¹⁴

While the provision of cash, help in kind, and services under law create different problems of administration, all create rights, without discrimination, for those entitled to them. The lack of clear remedies to enforce such rights has not only deprived those entitled to the benefits or services but has also opened the way to prejudice, discrimination, and apathy on the part of persons responsible for distributing them.

The practice in public assistance of making individual budgets for rent, food, special clothing allowances, special allowances for diets prescribed by doctors, special allowances for household articles, including beds and linens, open the door wide for discriminatory administration. For example, if a parent fails in July or August to request the necessary clothing items for children before school starts in September, or if a caseload remains uncovered so that no clothing allowance is granted until winter is well under way, who is responsible for the enforcement of rights?

When in an overcrowded area free public education is reduced to a double shift, with shorter school hours than in the other areas of the city, with more substitute teachers, and with no special classes for the gifted children as in other areas, what remedy do the poor have for this discrimination against their children?

When the government contracts for medical services for the poor, who can assert their right to adequate care? A recent study revealed that the voluntary clinics have accepted few poor children, and only those considered amenable to short-term therapy. The vast majority of the children most in need of therapy have had to be referred to clinics under public auspices. Overwhelmed by sheer numbers, these clinics can only do diagnostic studies and are unable to provide the needed therapy.¹⁵

Similarly, many voluntary agencies select the children who seem most likely to respond to their services, leaving those who are most deprived and who present the most serious problems to the public agency, which may not have a staff adequate to deal with them. When inferior, inappropriate services or placements are provided their children, poor parents have no redress.

By a series of separate and uniform State statutes and interstate agreements between welfare departments, the mobility of poor children in need of placement across State lines is being extensively denied. The practice has become so accepted that social agencies and courts often do not even explore the possibilities of homes among relatives in other States for children who must be removed from their own homes because of the death, mental illness, or neglect of parents. There is no one to speak for the

child, and there is no one to test the constitutionality of the laws under which the child is denied a home.¹⁶

It is not easy to separate the legal needs of the poor from the economic, social, and psychological disabilities imposed on them by society. It therefore becomes necessary to examine those areas in which law either by positive action or in negative fashion has added to those disabilities, and how law can become an instrument for lessening the disabilities and even freeing families and children from an oppressive denial of their rights.

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¹² *Wilkie v. O'Conner*, 261 App. Div. 373, 24 N.Y.S. 2d 617, 62 (1941).

¹³ Reich, Charles: Midnight welfare searches and the Social Security Act. *Yale Law Journal*, vol. 72, 1963.

¹⁴ Wickenden, Elizabeth: Partial check list of legal and constitutional issues affecting the rights of individuals seeking or receiving welfare and related public benefits. National Social Welfare Assembly, New York. Mar. 25, 1965.

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SIBLINGS OF THE RETARDED

I. A Guided Group Experience

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IN THE COURSE of providing group work services to retarded children during the past decade, the staff of the Association for the Help of Retarded Children in New York became impressed by the frequent references made by parents to problems these children created for their normal adolescent brothers and sisters, and vice versa. Parents expressed concern, for example, over the normal child's feelings of being overburdened by the care of the retarded sibling, of his overt expressions of hostility and resentment toward the retarded sibling, of responsibility for the retardation, of obligation to make up to the parents for what the mentally retarded brother or sister could not give them, and of guilt for being the normal child.

At the same time, the staff became impressed by the large number of normal adolescents who were taking their retarded brothers or sisters to social group meetings and to special events, and by other indications these young people gave of being able to cope with the fact of their sibling's retardation. Many of them obviously had been able to work out their feelings about their retarded brothers or sisters with no major intrapsychic, interpersonal, or intrafamilial strains, by developing healthy defenses and using compensatory mechanisms.

Thus with evidence both of need and strength in the normal adolescent siblings of retarded children, the staff began considering what the agency could do to include such young people in its total efforts to strengthen family life in the families of retarded children.

Consequently, with agreement from the appropriate lay committee, composed in part of parents of the retarded and the agency's board of directors, the decision was made to establish a demonstration program of guided group discussion for selected normal adolescents, through which they could examine, clarify, and understand more clearly a dynamic aspect of their life situation—their role as siblings of a retarded child. The experience in such a group, it was anticipated, would help these young people to become more effective and assured in their intrafamily relationships and responsibilities, and so would enrich the total family life.

More specifically, the aims of the demonstration were delineated as:

1. To assist the individual and the group to identify the nature of their reactions to having a mentally retarded brother or sister—stress, strain, mixtures of affection and antagonism—and the effects of these reactions upon their relationships with their parents, brothers and sisters, peers, and their entire life situation.
2. To help the individual and the group to examine and to clarify strategies for understanding and dealing with their siblings, their parents and peers, and the problems of daily living related to their status as the brother or sister of a retarded child—strategies which would be helpful not only to them but also to others in similar circumstances.
3. To throw light upon the extent to which the concern and reactions of such adolescents represent

strength as well as intrapsychic, interpersonal, and intrafamilial strains, and to determine whether their defenses are similar to or different from those of adolescents with no retarded siblings.

Since expressions of interest in the program came from all parts of the city, it was decided to conduct the group sessions at the association's office, which was centrally located. To qualify for admission to the group, an adolescent had to be between 13 and 17 years of age, and be willing to participate in the group sessions every 2 weeks to discuss his problems and feelings in relation to his retarded brother or sister and his life situation.

Twenty-eight adolescents met these criteria. Obstacles to attendance, such as the day, time, and travel involved, reduced the number selected to participate to 10. Twenty other young people were interviewed by staff members and helped to see why they could not be included in the group. These included several who were "pushed" by domineering parents to apply because "this is good for you," others whose parents expected the group to provide a therapeutic experience, and a few whose needs were basically social. For many of these young people, the group experience might have been too anxiety-provoking or otherwise inappropriate. Unfortunately, shortage of staff members prevented followup of those who seemed in need of individual counseling.

The 10 young people who formed the group included 5 boys and 5 girls, mostly from lower middle-class backgrounds. The age spread was from 14 through 17, with the boys generally 1 to 2 years younger than the girls. Six of the participants were in junior high school and four in high school. Judging from their own comments about school, seven could be considered above average in academic ability and three as average students; and seven were involved in extracurricular activities at school. All participants indicated a real desire to participate in this new experience.

All the retarded siblings of these young people were living at home. Some were mildly, some moderately, and some severely retarded. Half were younger and half older than the normal brother or sister.

The Group Process

The group, which its members called the Brother-Sister Group, met every 2 weeks from October 1962 through May 1963, under the leadership of a professional group worker. The first session was de-



A normal adolescent and a retarded friend who have learned to enjoy each other. Such relationships also exist between normal and retarded siblings in spite of the many problems an adolescent finds in having a retarded brother or sister.

voted to a consideration of the voluntary nature of the group and what the group hoped to accomplish. The adolescents agreed on their own accord to come regularly, and to share their problems and experiences in order to help not only each other but also other teenagers in similar circumstances.

At the end of each session the group agreed upon the focus of the next. In the beginning, the group worker took an active role in suggesting possible subjects for discussion, such as "How do you tell your friends about your retarded brother or sister? However, as the members became better acquainted and more comfortable with each other and the worker, they began to bring up spontaneously the concern they wanted to talk about. These included such questions as: "Does the fact that our family has a retarded member lessen our chances of marriage?" "How can we deal with the feelings we get when our friends show us pictures of their brothers and sisters and brag about their accomplishments?"

The participants offered little resistance to telling the group about their experiences with their brothers and sisters, families, and friends.

The worker helped the group look at different aspects of the material under discussion, adding information as needed, or raising questions and suggesting alternative courses of individual and group action. The worker also dealt with problems of individual needs and intragroup relationships. At the

same time, she helped the group hold to its aims and special function. She filled a variety of "roles"—confidant, leader, counselor, resource person, agency representative, and even parent—as the situation demanded and the group progressed.

By the fifth session a cohesive group had emerged, held together by a common bond and meaningful relationships between the members and between members and group worker. From that point on, the group was largely self-directed, taking major responsibility for the content of the meetings and for individual participation. The group worker became largely a resource person, who provided clarification of points, support for individual participants, and information to indicate alternative courses of action.

Each session lasted an hour and a half, and included a period of light refreshments provided by the agency. At the end of each, the worker summarized the progress made, emphasizing the positive, the constructive, and the realistic aspects. She encouraged the members to share their findings with parents, other normal siblings in the family, and friends; and to feed back significant reactions from them to the group. Such reporting back was frequent.

The group usually stuck with an issue until it reached a termination point. Completion of a subject of discussion sometimes took as many as three sessions. The group worker's attitude of constant acceptance provided a safe climate for the expression of concern and the ventilation of feelings whether these were of hostility, hate, or love. The participants also found support and recognition of the right to be different from their peers. They learned a method of analyzing life situations which was not only appropriate to the current scene but which could be used in dealing with future problems as well. Attendance at sessions over the 8-month period averaged 92 percent.

Concerns and Feelings

What were some of the common problems which emerged? The following list was prepared by members and group worker together. The illustrative material comes from the group records.

1. How do you tell your friends about your retarded brother or sister, especially friends of the opposite sex?

At this point, Bonnie turned to Susan and said, "Should I ask the question?" Both girls giggled, and Susan encouraged Bonnie to ask it. The question was: "How do you tell a boy that you have a retarded sister?"

Mark responded immediately by telling about his experience in telling a girl about his sister. The girls listened attentively, but then Susan said, "It's different telling someone that you really care about."

Susan is "going steady" and she hopes Stanley will never find out about her retarded sister, Gail. Could she tell why? She feels ashamed and embarrassed.

Kenneth said he knows how Susan feels, but he has been trying to help himself by asking whether he would be ashamed if his sister had no arm or no leg. He said knowing about this should have no effect on a person who had nothing to do with it, and if the boy really cares about you, this won't change him.

Kenneth told us that a few weeks ago a girl asked about his sister and he did not tell the exact truth. He felt ashamed about the way he acted and made up his mind to tell the truth the next time he saw this girl, but he just couldn't get himself to do it. He knows that it was wrong but he couldn't help himself.

2. How do you deal with your parents who have not discussed the problems of mental retardation in the family and their implications for you?

3. How do you deal with friends and people in school when you are hurt by their talk of the retarded as nutty and crazy?

4. Are these meetings really helpful or are we betraying our families' confidences?

5. Are our parents' expectations concerning our role and their role in continued care of our brothers and sisters, real and fair to all involved?

6. What should be our responsibility toward our retarded brother or sister in the event of our parents' deaths?

Even before the meeting began the teenagers were discussing among themselves the requests made by their parents for the care of the retarded sibling if anything ever happened to the parents. Regina and Diane have promised never to send their retarded siblings to an institution. Bonnie promised to visit her sister Barbara regularly in the institution. She would definitely not care for her if her mother were unable to do so. The other girls laughed at this and told Bonnie that she was "just talking" again, and that she would be the first one to object to having her sister placed in an institution.

7. What are we to do when our parents do not really feel affection for our retarded brother or sister?

8. How can we deal with our feelings when our friends show off their brothers' and sisters' pictures and talk about their accomplishments?

Bonnie broke in here and said:

"It is hard when you hear the other girls boasting how smart their sisters are, and the things they do, and you can't say anything about your sister. In fact, very often I do not admit that

I have a sister at all. Some of the girls in school think I am an only child and others want to know if I have a brother or sister since I never talk about mine. . . ."

9. Does retardation in our family lessen our chances of marriage, and is it hereditary?

10. How can our parents help us with our problems?

11. What can you do together with your retarded brother or sister in the home or in the community?

12. How does a teenager really accept a problem that he will face the rest of his life?

13. How can a teenager plan for his adult life?

14. What are our hopes for the future?

At this point Kenneth asked why Susan had such feelings about her sister. He thinks that they should all be very happy that they are living now when so much is being done for retarded children. Years ago people would hide retarded children, and nothing was done for them.

Bonnie said that was easy to say but the fact remained that the situation was hard to face. She says that she has heard all these things before. You are supposed to feel good because the President of the United States, who is very smart, has a retarded sister.

Other feelings expressed by participants in the group were: a feeling of not being loved as much as the retarded child; jealousy, resentment, and hostility toward the retarded child; denial of the severity of the retarded child's condition; and guilt about having negative feelings toward the retarded child. Such feelings, however, were not characteristic of the group, and their intensity in the individuals who held them was often repressed. The worker recognized their significance but did not delve deeper or bring them into focus before the group in view of the anxiety that would be evoked. Rather, she held to the group's educational focus, leaving the resolution of deep and involved feelings as the function of individual therapy.

As part of the group's activity, the worker suggested, after about 18 sessions, that the participants might want to consider ways and means of helping other young people who had a retarded brother or sister. This resulted in a group project, the writing of a pamphlet directed to other teenagers.¹

Some Observations

Over the 8-month period, the experience with these young people led members of the agency staff to make a number of observations. We present them as hypotheses which need further testing with a

larger number of retardates' siblings—young adults as well as adolescents:

About the Normal Adolescent

1. It was not the degree or kind of retardation in his sibling which seemed to affect the adolescent's life or happiness as much as the way he felt about himself and his retarded brother or sister, and the way in which he learned to live with the fact of having a retarded sibling.

2. What the normal adolescents really needed and wanted was accurate, up-to-date information, in language and concepts which they understood, about mental retardation and what they could do to help their families and their retarded siblings. They wanted to know how to manage *now* and what they could look forward to.

3. The young people's attitudes were not consistent at all times.

4. Almost every adolescent in the group brought up the question: "Why did it have to happen in my family, to us, to me?"

He said the question of "Why did this have to happen to me?" comes to him often. I told him this was a natural question, but said I wondered what it meant in the way of his making friends, or in school. . . . He said that it hadn't meant much up to this point but wondered what would happen when he has to tell a girl about his sister. I pondered that question too. (Kenneth is unable to use the word "retarded.") He said he would just say his sister was different.

Kenneth mused that everyone has something in their family. One of his friends doesn't have a father—parents are divorced. He can see this as a real problem. I asked him if this friend might also ask himself, "Why did this have to happen to me?" and he admitted that this might be so.

5. The sessions helped the teenagers see some of the strengths, as well as limitations, in their brother's or sister's functioning, and in the family.

6. The importance of good communication and feeling between parents and adolescent depended on the existence of the kind of relationship which encouraged the adolescent to go to his parents whenever he felt the need.

7. The teenagers seemed to be helped by the very fact of knowing that the agency was interested in them as well as in their parents and their retarded siblings.

8. The group worker to be helpful had to look at life as far as possible through the adolescents' eyes, show her care and respect for them, and treat them with dignity and understanding. She had to be care-

ful not to generalize and assume that the problems and feelings of all the siblings of retarded children are the same.

9. The group worker found it important not to underestimate the strength of adolescents or to expect too little of them. It was clear that the young people wanted their parents to involve them in planning for the total family.

About the Group and the Group Worker

1. The experience was appropriate for the adolescents in the group. They were able to express spontaneous feelings, to invest themselves in the experience, and to extract positive help and strength from their contacts with others who are in similar circumstances. For other adolescents such an experience may be anxiety-provoking to the point that the youngster is not able to handle his feelings appropriately. In some instances, such as when family relationships and parental roles were discussed, an adolescent's group experience carried a potential threat to his parents.

2. The meetings had meaning for the group not only in giving the young people help during a period of hardship, but also in helping them to maintain and build healthy family relationships.

3. The support of others—their peers and the worker—was helpful to these young people.

4. The size of the group was important. Ten members seemed about right for providing good opportunities for exchanging experiences and sharing the worker with each other.

5. Timing the meetings in relation to the many pressures on teenagers—school work, social life, family obligations, and work—was important.

Conclusions

Thus we concluded that this short-term group experience was useful to the teenagers involved. The spread of time helped the young people, at an age when it is difficult to put feelings into words, to open up problems, to delve into certain aspects of relationships, to pull together and integrate what had been accomplished, and to begin to think more realistically about the future.

The sessions did not always contribute to modification or change of basic attitudes, but they enabled the participants to know that others knew

and experienced similar problems and that it was all right to feel the way they did. Although their problems and feelings could not always be resolved since some were "bottled up" inside, for the most part these adolescents gradually became able to express their feelings more fully as meetings progressed and to become more realistic in their appraisal of them. This seemed to result in their being better prepared to see the next steps necessary in their planning. As time went on, they seemed to be able to look at the broader implications of mental retardation not only for themselves but for others who also had retarded brothers and sisters.

Many parents of retarded children are panicked into the belief that their retarded child will adversely affect his normal brothers and sisters. However, in some families where the parents have dealt with the situation constructively, such young people have developed greater maturity, tolerance, patience, and responsibility than is common among children of their age. Our experience suggests that the young person with positive family relationships is often capable of enduring the emotional hurt and anxiety of having a retarded sibling without severe disruption of his family and social life. He needs reassurance and support, but more often his primary requirements are educational. The more clearly normal siblings of the mentally retarded can see the realities of their particular situation, the better position they are in to cope with them. This is the point of a group experience.

As the young people wrote in their pamphlet:

... We helped each other. We learned how to "talk" about retardation and felt free to discuss our problems. We helped each other to be better prepared for any unexpected behavior of our brothers and sisters. We knew that we were not alone.¹

A fuller report of the project described here is available from the Association for the Help of Retarded Children, New York City Chapter, 200 Park Avenue South, New York, 10003, under the title, "Normal Adolescent Siblings of the Mentally Retarded: Some Beginnings in Guided Group Education."

¹ Brother-Sister Groups, Association for the Help of Retarded Children, New York City Chapter: It's tough to live with your retarded brother or sister. New York, 1964.

II. Individual Counseling

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WHEN a social worker is involved with the family of a mentally retarded child, he needs to maintain a continuing awareness of each of the other children in the home not only in order to learn more about intrafamily relations and their effects on the handicapped child and his parents, but also for the sake of these children themselves. If the normal children in the family have problems deriving from the presence of the handicapped child, the strain on the entire family may be aggravated.

Sometimes the social worker derives adequate knowledge about the other children in the family from the parents alone. However, the worker may enlarge his understanding of the family and perhaps modify his approach if he comes to know these children personally. This usually contributes to a greater sense of warmth and security all around, although some parents may feel threatened by the agency's contacts with other members of the family, a possibility which has to be considered in the plan for service.

Getting to know the handicapped child's siblings may be achieved by plan or by incidental meeting. At the Evaluation and Counseling Program for Retarded Children in New Haven, we have found that the informality of our office often encourages parents to bring in the entire family when they come for an appointment. In fact, if parents come from a distance they sometimes turn the trip into a family excursion, climaxed by a treat, and we encourage

this. Many of these families have experienced rejection and misunderstanding in the past. We try to make them feel accepted and at ease so that we can be of help to them in facing their problems. It might seem that the presence of several children for an hour or two in our small quarters could be disruptive. It sometimes is, but we find that we gain from each of these experiences both insight into specific family relationships and knowledge about the reactions of normal children to having a retarded brother or sister.

Out of such experiences grew our realization of the special problems faced by these normal children and of the help the agency could offer them. This, of course, varies with each child.

All that one 9-year-old boy needed to dispel his fears was to visit the office, see what went on in every corner of it, and meet the staff. He knew that his brother, a hyperactive child who was frequently in trouble, was undergoing evaluation, and he had reacted to this with symptoms of anxiety. At school he had been unable to concentrate. Assurances from his parents that nothing bad would happen to his brother had not helped him; but as soon as he entered the agency office on a visit with his parents his strained expression eased. Later, his mother reported that although he seemed less anxious after the visit, he was further relieved when the evaluation was entirely completed. He continues to be a very quiet boy who seems prone to worry, but, ac-

cording to information from the school, he is participating normally in the classroom.

Telling the Other Children

The question of whether older children should be included in family-staff conferences regarding a handicapped child is one which the parents must decide. The social worker can, however, help them make their decision. Various degrees of protective and dependent feelings, and sometimes sound understanding of what each child needs and can take, will enter into the parents' decision. What the conference is to be about will also enter in. If, for instance, this is to be the first interpretation of the diagnostic findings on the handicapped child, the parents may very well feel that they should come by themselves.

This leaves still to be handled the problem of interpreting the diagnosis to the other children. Usually parents will expect to do this themselves. In most instances, by the time they have come to the agency they have already established their own pattern for meeting children's questions, spoken or unspoken, about the defect, slow development, or strange behavior of a brother or a sister. They are most likely to continue to follow the same pattern to a large extent, although they may modify it in the course of their experience with the agency.

Even so, the parents may seek continuing or intermittent help with intrafamily relations. Such help may be given to them directly or in some other way. There are times, for example, when the parents will seek the worker's help in talking with an older child about a situation which has become very complex, which they feel they have been unable to interpret adequately or satisfactorily, or which has especially upset the child. Sometimes the child himself will signal his needs and a friendly conversation in the agency's playroom will lead into something more purposeful.

One 8-year-old girl, frankly acknowledged by her mother as "my right arm," was unable to remain away on any occasion when the parents brought her atypical younger sister to the office during an extended period of evaluation. She would at first express regret about missing play with her friends, but would then admit that she had insisted on coming because otherwise she would have felt anxious. She said she always liked to know what was going on. She did not, however, show interest in observing any of the evaluation procedures.

This child had a need to talk, and she showed that she thoroughly enjoyed and felt important in her

role as second mother to the retarded child. She said she wished her mother would have another baby. Then she said that she enjoyed those aspects of her sister's condition which made her continue to be a kind of baby. She told of extremely conflicting feelings. On the one hand, the thing she wanted most of all was for her sister to "get better." On the other hand, she wondered what it would be like not to have a baby in the house after being used to one for so long. She said she thought about this problem every once in a while.

The child's parents had tried to explain to her that her sister was not going to get better suddenly or dramatically. In talking with her, the social worker reinforced what the parents had said. Unfortunately, there was much about her sister's condition that was diagnostically baffling. The parents had been reacting to conflicting professional opinion and had not been able to keep their rising and falling hopes from the older child.

In the course of time, this little girl has seemed gradually to accept the fact that great change in her sister's condition is neither to be hoped for nor feared. She spends less time at home now. Her mother feels less guilty and depends upon other sources for help.

Anne's Case

In other instances, we have felt it necessary to offer more formal and prolonged casework service to a sister or brother of a patient. There was, for example, Anne.

Anne was 12 years old when her parents asked for evaluation of her 5-year-old brother, Freddy, a severely retarded, spastic child who was hyperactive and extremely difficult to control. To an increasing extent the life of all members of the family was being geared to Freddy's needs.

Freddy had been on the waiting list for admission to one of the State training schools for about 4 years. However, the parents were not sure that this was what they really wanted. They had sought an evaluation of Freddy by the agency to help them make a decision and be prepared if the opportunity for admission occurred.

The workers first impression was that this was a very close family. All members, including Freddy, had a generally pleasing appearance. The mother looked careworn, but was very bright and controlled. The father, a clerical worker, was affable and mild in manner. He was extraordinarily patient with Freddy. Anne was pretty, serious, and even sombre.

Later it was discovered that she was capable of great animation. Her 8-year-old brother, George, had a ready smile.

Anne seemed to feel a great deal of responsibility for Freddy. The mother said that when Freddy wanted to be comforted he would go to Anne; when he wanted to play, he went to George.

The parents were direct in their discussion of Freddy, but they tended to deny their own deep feelings about him. While they accepted the offer of continuing service from the public health nursing consultant, they made only limited use of the agency's help. By the time of the staff-interpretation conference, they had about settled on residential care as the ultimate plan for the child.

In spite of their independence in planning for Freddy, these parents admitted a sense of inadequacy in regard to Anne. They said they knew that she was deeply concerned about the home situation, but that she would not talk to them about this. They eagerly accepted the offer of an opportunity for Anne to talk alone with the worker, and Anne also responded positively.

The social worker had four interviews with Anne. The girl used them primarily to ventilate her feelings. These related to her sense of being repressed at home, to her relations with each of her parents, to George and Freddy, and to friends at school.

Anne announced from the start that she had accepted the fact that the plan for Freddy was to go to training school. She seemed to look forward to it as possibly providing some relief and relaxation of the tension at home. Her understanding was that they would be able to bring Freddy home for visits frequently.

Anne expressed a sense of rivalry with her mother. She was convinced that she understood Freddy and that when her mother was not there to interfere she managed him well. She felt that he could be taught to do more for himself but that her mother lacked the patience for this. For instance, Freddy had not learned to wash his hands because if he dropped the soap he would have a tantrum and refuse to try again. Anne thought that he could be helped to learn by repetition, and she told of an instance in which he had, but this kind of procedure was very frustrating to her mother.

Anne said she thought that one possible advantage of the training school would be that Freddy would be taught how to develop his potential. She used part of one interview to ask about learning processes, and told of how she was able to apply some principles of child development she had learned in school. When asked if she thought her mother might be interested in knowing about these principles, Anne seemed to shrink. She said her mother would not converse with her on that level; that her mother regarded her as only another child.

Anne felt that she was different from her mother, stronger in that she did not talk about her troubles—"I'm more like Daddy." At the same time, she recognized that things were

hardest of all for her mother because she was in the house all the time. She was pleased when her mother joined a sewing club.

Anne said she knew she was considered to be a serious person, but that this was only at home—"Outside I'm like everyone else." She expressed ambivalence about George and commented that he had a good understanding of Freddy, "More than I did at his age," and that "this probably will mature him mentally." She was frankly envious of George's ability to enjoy his own life to the full and of his imperviousness to scoldings.

George and Freddy would fight, and this distressed Anne. Their behavior interfered with her homework and for a while she was getting up at 5 o'clock every morning to study French.

Anne found real satisfaction in her relations with Freddy and in his response to her. She delighted in talking about him, and about what he liked to play. She liked to provide him with new experiences. One spring day she let him splash in the mud and she thought this did something for him. Her mother, who has very high standards of neatness, was upset.

Although she could see weaknesses in her parents and felt that in many ways she could do better, Anne was not entirely uncomfortable in her role in the family and in the protective structure which her parents had placed about all their lives. Although many of her observations and reflections showed capacity for independent thought, many of her concepts and values, and even expressions, reflected those of her parents.

An acute problem for Anne related to community attitudes toward Freddy. She found it hard to tell people about him and was especially afraid of telling her schoolmates. About 2 years previously, the family had moved to a suburb from the city. She found herself a newcomer in a school in which most of the children were from families of higher economic status than her own and, she thought, more secure socially than hers. There was one girl whom she admired very much. Once when retardation was mentioned in school this girl said, "But those children look awful." Nevertheless, Anne wanted to be liked by her. She held back from social opportunities out of shyness but accepted an invitation to the girl's home. She realized then that she was well accepted but she continued to fear that this would change if the family problem became known.

Anne thought that she would never have the courage to tell her schoolmates about her brother's condition herself, and that she would be considered deceitful if they learned about it in another way. She and the worker discussed this problem at great length, but Anne could not work out any entirely satisfactory plan for handling it. She was pretty sure that not many people in the community knew about Freddy, although a few of her new friends had seen him when they stopped at the home one evening to pick her up for a party. When the worker asked what their reaction to Freddy seemed to be, she said all they seemed to have seen was a cute little boy. He had looked appealing at the moment. He had just had his bath and was ready for bed. She was sure they had not noticed

anything. The girl about whom she was so concerned had not been in the group.

Anne's closest friend was a girl from her old neighborhood. She knew all about Freddy and about Anne's problems concerning him. Fortunately, Anne had been able to continue in a close relationship with this trusted friend.

When the worker asked Anne if she had ever had any experience of her own which would be useful to her in understanding the reactions of others to Freddy, Anne recalled that many years ago, before Freddy was born, a child visited the family who did not talk. She had not been aware then that there was anything else wrong but now she knows he must have been retarded. She and George played with him, and she remembers now that his parents seemed very pleased. The worker asked how she thinks of this person now. She closed her eyes and then said, "Someone nice." She said she was afraid, however, that some people are prejudiced against a retarded person before they even meet him.

At her third interview, Anne reported that her father had an opportunity for a job transfer which would have some advantage for him. It would mean moving out of the State. Her mother was not in favor of it, on the grounds that the family might suffer a financial loss in giving up the present home and acquiring a new one elsewhere, and also that the family needed to make sure of Freddy's continuing eligibility for admission to the training school for retarded children.

Anne said, however, she thought the real reason her mother was against the transfer was that she did not want to move away from friends and familiar surroundings. Anne did not know what her father really wanted to do, but she felt that he must want a change because for 18 years he had been working in close association with a person whom he "couldn't stand." This would be his last chance to change because he had declined a previous offer. Anne said she was feeling more and more puzzled at her father's way of giving in to everyone. She told about how he spent every Sunday driving two sets of relatives between their homes and her family's.

Anne was not quite certain what she preferred herself but she leaned toward the move. The problem of informing new friends about Freddy would come up again but perhaps she could make a different kind of start. She pointed out that although she knew about the question of the move and some of the circumstances related to it, she did not know just where her parents were in their thinking since they did not include her in making any decision of this kind.

At the next interview a few weeks later, Anne said that she did not know what the final decision about her father's job was or if it had yet been made, but she knew one thing was certain: whatever the family did and whatever happened in their house in regard to almost any thing would be what her mother

wanted. She seemed a little relieved by her own ability to recognize that this was a fact of her existence.

Anne seemed less concerned about the home situation now and more about school. She groaned when she said that she sometimes felt that she would never get into college. The end of the school year was approaching, however, and she was looking forward very eagerly to a 3-day trip to Washington with a group to which she belonged.

At the end of this interview, Anne was not sure whether she needed to come to the agency again, so it was decided that the interviews would be terminated until she felt she wanted to resume them.

We have had no further direct communication with Anne. Her father was waiting as she left the office. In passing conversation, he revealed that the plan for job change had been definitely rejected.

A few months after this, Freddy was admitted to the training school. The mother reported that they had had to act on short notice and that perhaps this was good. She said she thought her husband was feeling the separation hardest of all. As for Anne, her mother said she seemed happier, "a changed girl."

Counseling service for the father was offered at this point but declined. The mother explained that she and her husband understood and valued the agency's interest but that they always felt that they should handle problems themselves as much as possible. She sent a message to the worker with the assurance, "We're doing all right."

The Meaning

Perhaps the agency might have given more help to this family, especially toward precipitating better communication among the members. The help which was provided, however, was in an area concerning which the parents recognized a need. It harmonized with the family's basic goals, although the parents' immediate goals were not identical.

For the girl, the agency's service provided an urgently needed outlet. In helping her, it released some of the tensions in the entire family. It also helped to increase the agency's own understanding of some of the problems faced in the homes of retarded children, the strengths which may be found in them, and the importance of giving them support.

Based on a paper prepared for a social workers' institute on mental retardation, sponsored by the Connecticut State Department of Health and the U.S. Public Health Service.

PARENTAL CONTROL AND PARENTAL LOVE

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SINCE THE TURN of the century, behavioral scientists have shown increasing interest in child-rearing practices. However, theoretical formulations from one period to the next have been in sharp contradiction. The proscriptions of early behavioral theory intended to prevent spoiling became the prescriptions of psychoanalytic and non-directive theory, in order to avert frustration and submission. The procedures advised by the behaviorist Watson in the early part of this century were specific and pertinent, but, according to later theorists, had injurious side effects on the young child. Watson's proscriptions on coddling and tending to the baby's comfort violated normal maternal desires to nurture their young. However, the theory of psychosexual development from which the later child-rearing ideology arose often frightened and bemused the conscientious parent who was cautioned to "behave naturally" but not to overstimulate, restrict, or express hostility toward her child.

Child-rearing theory of today has synthesized many of the central tenets of the conflicting theories of the past. In the past, Watson emphasized the control functions of child rearing while Freud and

Rogers emphasized the nurturing functions. However, today's theories suggest that the lack of parental discipline may make a child insecure about parental love, and conversely that an unloving parent is not likely to successfully control her child's behavior.

This hypothesis and its reverse—that a combination of parental warmth and discipline produces a self-reliant, buoyant, self-controlled child—has received some support through an investigation undertaken in 1963 at the Institute of Human Development, University of California, Berkeley. The purpose of the study was to determine whether preschool children who are self-reliant, self-controlled, buoyant, and affiliative (Pattern I in the investigation) are reared by their parents in a different fashion from children who are discontented, withdrawn, and distrustful (Pattern II), or children who have little self-control or self-reliance and tend to retreat from novel experiences (Pattern III).

Thirty-two children who manifested these three prototypic social attributes to a high degree were selected for three study groups (composed of 13, 11, and 8 children) from among 110 normal preschool children, who attended the H. E. Jones Child Study Center at Berkeley, after 5 months of observation in nursery school and laboratory settings.

Based on research supported by a grant (MH-03991) from the National Institute of Mental Health, U.S. Public Health Service.

Parent-child interaction data were obtained by means of interviews, home visits, and structured observations. All parents whose children were chosen for the investigation cooperated in the study.

The interviews and observations were designed to obtain characteristic expressions of four interaction dimensions—parental control, parental maturity demands, parent-child communication, and parental nurturance.

Parental control refers to the socializing functions of the parent, that is, to those parental acts which are intended to shape the child's goal-oriented activity, modify his expression of dependent, aggressive, and playful behavior, and promote internalization of parental standards.

Parental maturity demands refer to the observed and reported expectations which the parent has of the child in intellectual, social, and emotional spheres, relative to the child's age, abilities, and past performance.

Parent-child communication refers to the extent to which the parent shares with the child her objectives for the child, solicits his opinions and feelings, exhibits attentive and patient interest in the child's efforts to communicate, and comprehends the child's perspective in adult-child interactions.

Parental nurturance refers to the predilection of the parent to perform the caretaking functions. Nurturance is composed of *warmth* and *involvement*. By *warmth* is meant the parent's personal love and compassion for the child expressed by sensory stimulation of the child, verbal approval, and tenderness of expression. By *involvement* is meant identification by the parent with the behavior and feelings of the child, her pride and pleasure in the child's accomplishments, and her conscientious protection of the child's welfare.

Conceptual Approach

Before going into the details of the study, it seems pertinent to describe the conceptual approach to parent-child relations from which it proceeds. This assumes that the physical, cognitive, and moral development of preschool children is largely a consequence of parental attitudes and child-rearing practices.

A child's energy level, vigor, and alertness are set not only by genetic structure but also by the diet and health regimen provided by his parents. The child's inherent cognitive potential is stimulated by a rich, complex environment—or inhibited by impoverished surroundings. He is taught language, how to interpret and use his experience, and how to reason

logically. Parents also teach their children how to relate to others, whom to like and emulate, whom to avoid and derogate, how to express love and animosity, and when to withhold response. The child learns to aspire toward the noble and the ideal—or to be satisfied with the ordinary and the tangible. The child, by seeing himself through his parent's eyes, learns to know his own characteristics and what value to place upon his attributes.

Later, the child's self-image is enhanced, or otherwise altered, by the attitudes toward him of other adults and children. He is evaluated by these others without the leniency expected from loving parents. He is loved if he is lovable, enjoyed if he is personable, avoided if he is irritating, and humiliated if he is incompetent. He is evaluated and reacted to in ways determined by attributes which his parents have to a large extent already shaped, by their own actions or the actions of others whose influence upon the child they have invited.

Although it has been fashionable for some time to pretend that children are not, or at least should not be, their parents' creations, both research findings and common sense demonstrate that, with varying degrees of consciousness and conscientiousness, parents do in many ways create their children psychologically as well as physically. Children commonly model themselves after their parents. The parents' use of reinforcement, whether punishment or reward, will be effective to the extent that the underlying parent-child relationship becomes one of mutual love, respect, and trust.

Normally, as the child matures, the parent's current influence upon him diminishes and the influence of peers increases. However, the more the child has internalized the parent's value the more likely he is to seek parental guidance and to come to decisions which his parents can affirm. At the same time, the parent learns to trust his child sufficiently to learn, through him, the values and wisdom known best to the new generation.

The assumptions about the meaning of love implicit in the child-rearing models prevalent in the forties and fifties may have deterred parents from fulfilling certain important parental functions. Love was seen as coterminous with kindness, understanding, and self-sacrifice. Such "kind love" is passive with respect to its object, not requiring that its object become good, or knowledgeable, or disciplined—only that it be happy. It appreciates the child as he is and does not try to shape or alter his autonomous development. It is content with providing nourishment and under-

standing. It gives generously and demands little from the loved one.

The effect on the child of kind, understanding, self-sacrificing mother love may not be entirely salubrious. Once the child enters the larger community, the parents are forced to restrict or deprive. Accustomed as the child is to immediate need gratification and tension reduction, he suffers greater deprivation at such times than the child who is consistently disciplined by his parents. Acting as she is against her love ethic, the mother feels ambivalent about restriction and punishment.

Instances in which praise is used contiguously with punishment tend to nullify or reverse the deterrent effect of punishment. The use of praise in this way also tends to hamper the child in his ability to distinguish between good and bad acts. The parent's ambivalence and resultant guilt and self-depreciation may add to the child's burden of anger and frustration at being restricted or punished.

The mother who expresses love only by kindness, understanding, and self-sacrifice expects of the child, in relation to herself, a reciprocal, not an imitative, response. She permits the child to be selfish and demanding while she herself is not. If the child identifies with the mother's image of herself but is not punished when he behaves in disaccordance with it, he is likely to feel shame at what he is and conflict about what he should become.

Parental love need not be viewed as coterminous with kindness, understanding, and self-sacrifice, although these are among its ingredients. The parental love ethic may include authority, demanding of the parent active, vigorous interaction with the child. The authoritative mother rises actively to meet the developing adult within the child even as she enjoys his predominantly childlike qualities. Such a mother recognizes herself as a senior member of the family—one therefore required to be nobler, stronger, wiser, and more reasonable than the child. She recognizes that, as his creator, she has, in the eyes of her preschool child, divine attributes. Instead of denying this role, she tries to behave toward her child in a way that will justify the child's trust in her authority and maintain his respect even after he surrenders belief in her omnipotence.

The authoritative mother may use the experience of parenthood to become more admirable, to base her authority increasingly on reason and virtue and not on the child's relative impotence. Here authority has, as its aim, shaping the child in accordance with her image of the noble, the beautiful, and the best,

and imparting this image to the young child as an initial model upon which he can create his own ideal.

Unlike the *authoritarian* parent, the *authoritative* parent maintains control without impeding the child's autonomous thrust, and encourages rather than suppresses free expression of divergent opinions. The authoritative mother does not mute the conflict which her demands upon the child, and his upon her, engender. But through it all, she asks for his best; she applauds the real, and stands for the ideal, until the child is ready to construct personal ideals which are consistent with the tasks of his own generation. The kind of parent-child conflict which is produced by authoritative parental love tends to free the child to know, and then surpass, his parents; to respect, yet finally overcome, their power and the precedents set by their generation.

The Study

On the basis of these conceptions our study hypotheses were as follows:

Effects of Parental Control. High parental control should be associated in the preschool child with high self-control, self-reliance, and buoyant mood, if parental nurturance is at least average for the population studied. Low parental control combined with higher nurturance should be associated with low self-reliance, avoidant behavior, and low self-control in the nonclinic preschool child.

Effects of Parental Maturity Demands. The effects of high maturity demands upon the child's self-reliance should vary, depending on the degree of parental nurturance and parent-child communication. When the parents are highly nurturant and communicative, high maturity demands should increase the child's self-reliance. When the parents are non-nurturant or noncommunicative, high maturity demands should be associated with medium or variable self-reliance in the child. Low parental demands for maturity should be associated with low self-reliance and low impulse control in the child.

Effects of Parent-Child Communication. High parent-child communication should augment the effects of high control and high maturity demands on the child. It should contribute to the child's sense of well-being and his interpersonal competence, as do other manifestations of nonindulgent nurturance.

Effects of Parental Nurturance. Low parental nurturance will be associated in the child with discontent and withdrawn, distrustful behavior. High parental nurturance should accentuate both the posi-

tive effects of high parental control, and the negative effects of low parental control.

Specifically, it was predicted that:

1. When contrasted with other parents, parents of Pattern I (mature) children will be rated high in control, maturity demands, parent-child communication, and nurturance.

2. Parents of Pattern II (disaffiliated and discontented) children will demonstrate less nurturance than parents of Pattern I and Pattern III children, and less parent-child communication than parents of Pattern I children.

3. Parents of Pattern III (immature) children will demonstrate less control than parents of Pattern II and Pattern I children, and make fewer maturity demands than parents of Pattern I children.

Settings and Procedures

The interaction dimensions were defined operationally for the structured and natural settings. During the structured observation at the child study center, mother and child were offered teaching and play material designed to elicit theoretically meaningful behavior in standardized form but without interfering with the spontaneous interplay of mother and child. The home visit, on the other hand, permitted observation of all family members in a natural setting providing spontaneous instances of the phenomena later coded in prearranged categories. In both situations, natural and structured, an attempt was made to preserve the phenomena observed by the method of reporting and the system of categorization.

The Home Visit. The home is the most convenient natural setting in which to observe family interaction, the one which permits observation of all family members engaged in their customary pursuits and using familiar paraphernalia. Even with an observer present, members tend to demonstrate habitual response tendencies to the normal but urgent demands of home life at crucial periods during the day.

The family was observed in the home during two periods selected to elicit a wide range of critical interactions under different conditions of stress. The first period, lasting from just before dinner to the child's bedtime, was chosen so that the family would be seen during a period of maximum interaction and stress. The second period, by contrast, was chosen by the mother as a time which she thought of as least stressful for the child and for herself. Each visit lasted 3 hours.

During the home visits, the observers described in

detail those parent-child interactions in which one member attempted overtly to influence the behavior of another. All interactions were coded after the home visits were concluded. Control sequences and noncontrol sequences were identified. A control sequence consists, by definition, of two or more causally related acts containing a single message and involving the same two family members as participants in an interchange initiated by one of them to alter the behavior of the other and ending with the other's compliance or noncompliance. A noncontrol sequence has no initiator or outcome, but otherwise has the same definition. If more than two family members were involved in an interchange, sequences were scored for all pairs of participants separately.

Coded elements of the sequence included the participants; substantive message; degree of power and kind of incentive used by the parent to motivate the child; the manner in which the child complied or failed to comply; and, where appropriate, child satisfaction.

Three kinds of sequences were identified:

1. *Parent-initiated control sequences*, intended to control or alter the child's behavior or future capacity to act. In this type, the parent directs the child's behavior, impelling the child by power, incentive, or both. The child responds by complying or not complying. He makes a decision immediately, or following a number of interpersonal maneuvers with the parent who initiated the sequence. These maneuvers and the results, in terms of compliance and noncompliance, are called the control-outcome rating. The nature of the demand made upon the child determines the message code. The following is a Type I sequence in which the parent uses minimal power and the child complies after the parent persists:

Mark gets up from the table.
Father: "What do you say, Mark?"
Mark: "I wanna go."
Father: "What do you say, Mark?"
Mark: "Excuse me, please."

2. *Child-initiated control sequences*, in which the child makes a demand of the parent with which the parent complies or fails to comply immediately, or after further interaction with the child. The following is a Type II sequence with which the parent fails to comply, although the child uses increasingly greater power:

John: "Can I go out?"
Mother: "Yes. Oh no, I guess you can't. I didn't realize how late it was."

John: "But why didn't you tell me the time?"

Mother: "You have to take a bath now."

John: "Please, Mother. (Crying, beseeching, being terribly cute.) I never get to go down the street."

Mother: "Not tonight, dear."

3. *Parent-initiated noncontrol sequences*, in which both parent and child participated without intending to alter behavior and usually for mutual pleasure. The following is a Type III sequence:

Mother: "Shall we have dessert now?"

Everyone rushes to the table and the family chats amiably while eating.

The Structured Observation. The structured situations consisted of a teaching situation in which the mother was asked to teach the child elementary numerical concepts, using appropriate equipment and an attractive play situation in which the mother could interact or not with the child, as she chose. The play equipment included a miniature city, toy kitchen center, and water play materials.

The teaching situation was arranged in the playroom with the child facing the play materials. This had the effect of producing a divergence of interests between mother and child, thus eliciting instances of parental control which could be observed. During the structured observation, items of behavior describing the mother-child interaction were checked. Following the observation, the experimenter and an observing psychologist filled out summary ratings independently.

Conclusions

Selection procedures do not permit drawing obligatory causal conclusions from our data since the number of children and parents observed was restricted by the pattern requirements. Nonetheless, it appears from the data that parental control and nurturance interact collaboratively, and that a pattern of parental behavior high in control and high in nurturance is more likely to produce self-assertive, self-confident, and self-controlled behavior in young children than is any other pattern of parental behavior.

In other studies,^{1, 2, 3} where contrary findings have shown parental control to be positively associated with discontent or dependence, the operational defini-

tion of control has generally emphasized severity of penalties, restrictiveness, parental disapproval, or lack of communication between parent and child. It is reasonable to conclude that one or more of these variables was the crucial antecedent resulting in discontent or dependency, as was the case with Pattern II parent-child pairs.

Parents of Pattern II children, when compared with parents of Pattern I children, fitted the usual definition of the authoritarian parent in that they reasoned less, inflicted severer penalties, used more disapproval, and were more coercive in their use of power. Since parents of Pattern I children were rated even higher in control than parents of Pattern II children, but were not rated as authoritarian or non-nurturant, it seems reasonable to conclude that the disaffiliation and discontent shown by these children resulted not from high control but from low nurturance, or authoritarian parental behavior, or both.

To the extent that our results are generalizable self-sufficiency and impulse control in the child are not as affected by parental nurturance as by parental control, since Pattern III children, whose parents were markedly low in control but higher in nurturance, were low in impulse control and low in self-sufficiency, although they were not discontented and socially withdrawn.

The thesis can be supported, from these results, that the processes we call control and nurturance are synergic and that the approach designated as authoritative love integrates the two central parental functions of control and nurturance, so that these functions are perceived by parent and child as unified manifestations of parental love.

¹ Schaefer, Earl S.; Bayley, Nancy: Maternal behavior, child behavior and their intercorrelations from infancy through adolescence. *Monographs of the Society for Research in Child Development*, vol. 28, no. (Series no. 87), 1963.

² Becker, Wesley C.; Peterson, Donald R.; Luria, Zella; Shoemaker, Donald J.; Hellmer, Leo A.: Relations of factors derived from parent interview ratings to behavior problems of 5-year-olds. *Child Development*, September 1962.

³ Kagan, Jerome; Moss, Howard A.: *Birth to maturity: a study in psychological development*. John Wiley & Sons, New York. 1962.

The child needs strength to lean on, a shoulder to cry on, and an example to learn from.

Vice President Hubert H. Humphrey, at the National Conference on Day Care Services, Washington, D.C., May 1965.

CHILD REARING IN THE SOVIET UNION

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EVIDENCE of dramatic changes in the Soviet Union since the death of Stalin has stimulated an increasing interest on the part of Western observers in social and educational developments among the Russians. It therefore seems pertinent to review a number of recent books and articles dealing with aspects of family and child life in the Soviet Union.

It is difficult for an American to write a book about child rearing in the Soviet Union. Indeed, it is usually a difficult assignment to write about child rearing in any country except our own, and even then the careful analyst faces many a quandary. The number of dependable, comprehensive research reports on American parental conduct can be counted on the fingers of two hands—perhaps even one. To be sure, we have countless isolated small-scale reports on tiny behavior-bits in the mother (or father) and child interaction, and we have various vague attitude studies, but it would take a brave child development specialist to stand up and deliver a 45-minute address entitled: "This Is How American Parents Raise Their Children."

With respect to the Soviet Union, we do not even have the studies of behavior-bits and the vague attitude studies. What we do have is a massive assortment of hortatory and theoretical preachers. We are aware that the

powers-that-be in the Soviet Union desire to bring forth a breed of "New Socialist Man" who will be a faithful son or daughter of "true Marxist-Leninist humanism," and that this new man will be recognizable by his excellent health, undeviating morality, clean sexual habits, love of labor, and vigorous team spirit. In other words, he will be exactly like a "good red-blooded American."

And that is about all that we do know. When it comes to how Ivan's mother brings up Ivan, we have only the faintest notion as to what goes on in those endless blocks of drab apartment developments on the outskirts of Leningrad, Kiev, and other towns in the Soviet Union.

Family Life

The Communist view on child rearing and family life resembles a pendulum swinging jerkily between a point on the left called "public" or "collective" care and a point on the right called the "humanistic family" or, perhaps, "genuine individuality" (certainly not "individualism"). Marx and Engels started it off with their iconoclastic reference to "bourgeois claptrap about the family . . . the hallowed relationship between parent and child"¹ followed immediately by their idealized references to a humanity united into a great and universal family in which all ego-

istic and exploitative relationships would have been abolished. In a recent study of marriages in the U.S.S.R., a Soviet sociologist hews to this time-honored Communist view by averring that a system based on private ownership stimulates the "motives depriving marriage of its very essence," and that the socialist system creates an atmosphere most favorable to love matches and unfavorable to the concept of marriages of convenience.² No evidence is offered to substantiate this view.

The traditional Marxist ideal of marriages of ideological purity and tender love, producing offspring to be reared in wholesome collective settings, and the considerable ambivalence within this ideal, has received perhaps its most characteristic and sophisticated expression in the writing of Anton Semenovich Makarenko (1888-1939), who in addition to being one of the most creative and innovative pedagogues of his day,³ has some very perceptive things to say about the potentialities and pitfalls of family life.⁴ Some acquaintance with Makarenko's writings is essential to grasping the official Soviet approach to childhood and the family.

Perhaps the best one sentence summary of the official Soviet line is this one: Children must be brought up socially and collectively, but the family must be intimately involved in the process. Precisely how this is to be done,

however, presents endless problems.

One thing, in any event, is clear. The vast majority of Soviet children are not being reared "collectively," but more or less according to the school-home pattern that prevails in our society. Despite the intention to make the boarding school (*shkola internat*) the universal institution of secondary education, even according to the most optimistic calculations, it will take until 1980 to bring one-third of the youth into these boarding schools.⁶

Child Rearing

Herschel and Edith Alt have undertaken the thankless task of explaining to American readers something about child care in the Soviet Union. During their first visit to the Soviet Union in 1956, they spent several weeks in the major cities investigating schools, health services, welfare institutions, and facilities for the retarded. The result was a volume,⁶ both chatty and informative, which for the most part reaffirmed current and generally accepted viewpoints among American specialists on child welfare who are interested in child welfare in the Soviet Union, but which also opened up a number of important questions for speculation.

The Alts made a second trip to Russia in the summer of 1959, this time to probe in greater detail Soviet educational theory and the practical as well as theoretical approach to shaping the child's personality in the familial and social setting. Their second report⁷ consists in large part of a theoretical discussion of the various effects of Communist ideology on the growth and development of the personality under conditions of urban living in the Soviet Union.

The book is written from a "mental hygiene" point of view. The authors believe that "the problem the U.S.S.R., no less than the capitalistic nations, faces at this time is essentially a psychological one." Many other observers of American as well as Soviet life would deny that this is the best definition of the essential problem, maintaining instead that the chief issues in both societies stem from economic, social, and political conditions that have pervasive effects on individual psychology.

A persistent refrain of the Alts' second volume is that Russian educational leaders and theoreticians are dogmatic, stubborn, and zealous in adhering rig-

idly to a one-track pursuit of goals; that the ideology is unyieldingly opposed to modification or revision; and that there is a refusal to make objective appraisals of basic educational theory and methods. But the Alts also cite numerous examples of changes, shifts in policy, dramatic reversals of school organization and curriculums, sweeping reforms, vigorously conducted debates in the press, and openly acknowledged clashes in viewpoint among prominent educational leaders.

The Alts maintain that the official Soviet policy is fundamentally distrustful of the family, and that it is baffled, confused, and unsettled in its attempt to leap over the parental home as the traditional child-caring milieu. At the same time, they point out that the Soviet Union supports a program dedicated to the proposition that the family is the basis of society and that the upbringing of children is a 50-50 partnership between home and school.

Like the Alts, other Western, particularly American, analysts of Soviet society have tended in the past to stress the more rigid and constrictive elements in Russian child-rearing and educational practice, of which there has been ample evidence. However, since the death of Stalin, there has occasionally come to the fore a more cautious viewpoint, one that emphasizes the cooperative and reflective elements in Soviet pedagogical theory. For example, an American psychoanalyst, reviewing the tenets of Western ego psychology as contrasted with the official Soviet psychology, concludes that both theories "have reached quite similar formulations re the relative autonomy of the adult personality and the moral responsibility of the individual."⁸

Educational Goals

Allen Kassof's study⁹ of Communist youth organizations (Komsouol, Pioneers, and Octobrists) offers evidence that youth leaders do in large measures stress forms of autonomy and the moral responsibility of the individual, while placing chief emphasis on the inculcation of work and achievement values. Kassof concludes, however, that the liberalism of the post-Stalin era has not significantly altered the "traditional narrowness and inflexibility" of the youth program, nor does he believe that the day is yet near when Soviet youth will be granted true freedom and au-

tonomy. Still, Kassof says that there is a positive aspect to the youth program in that—

... it gives official recognition to youth as a partner in the larger societal undertaking and thereby provides a sense of identification and purpose that so often is lacking among youth in modern societies. Granted that this recognition is in large part a disguise for an extreme form of tutelage by politicians and administrators, it is recognition nonetheless and should not be underestimated. Moreover, by dealing with youth in adult terms—that is, by insisting that young people function according to rules rather than in terms of an adolescent or youth subculture—it may be that the new generations are more readily incorporated into the "serious" concerns of a growing industrial order.¹⁰

Nigel Grant has written a brief account of Soviet education in the nonsense and unbiased British manner, although perhaps a bit too much gets taken at face value. He sees much that is flexible, sensible, and useful in the Soviet approach to educating the young, but he concludes that from a British or American viewpoint "the rigidity of the Soviet school system is almost frightening."¹¹

According to Grant, the educational reforms and the general political-cultural thaw have not served to relax discipline and stern moralizing: Children are expected to be very good indeed, undeviatingly conscientious, and never to challenge the Soviet teacher, who would be horrified at our notions of democratic planning in a pupil-centered classroom.

Despite the hazy Soviet statistics, we are probably justified in concluding that more American than Russian children get to see the inside of a schoolroom under the age of 7, although this may not be the case 20 years hence. The traditional Russian system of a granny (*babushka*) providing a large share of babysitting is still widespread. As for the problem of dropouts and educating "all the children of all the people," most observers now believe the situation is worse among the Russians than among us. It remains a curiosity of the past decade of American writing on Soviet education that we so greatly overrated Russian achievements.

That flesh-and-blood encounters are not necessarily superior to well-spent hours in the library is a thought that comes to mind when we read Helen B. Redl's eclectic collection of translations from the Russians.¹² One might

quarrel with some of the choices—there is no quarreling, however, with Fritz Redl's fine introduction on the perils of cross-cultural observation. On the whole the 15 selections—on discipline, sex education, the father's role, the family, boarding schools, children's literature, and moral and character training—are a suggestive survey of Soviet views on the child's place in society, especially if the reader does not always resist the temptation to read between the lines.

For example, in a 1925 essay of Krupskaya (Lenin's widow) one encounters the statement, "To create a definite plan of action and to proceed accordingly is very important, since we Russians have yet to develop the habit of planned work." Ah, one thinks to oneself, is that what so many of those early educational twists and turns have been about—to get the Russians "to develop the habit of planned work?" Thirty years later, Krupskaya's ingenuous comment stands in sharp contrast to the boastful claims of the educational planners and organizers writing today. Have they really achieved what they set out to achieve, or are they trying to give themselves the impression that they have?

The enormous task imposed on Soviet education in the aftermath of the Revolution becomes clearer when we consider the transformation in the class structure that has taken place over 45 years. Late in 1964, *Pravda*, the official organ of the Communist Party of the Soviet Union, published figures which showed that between 1928 and 1962 the number of blue- and white-collar workers rose from 17.6 percent of the total population to 73.6 percent and the number of collective farmers and cooperative craftsmen, from 2.9 percent to 26.3 percent; while the number of independent farmers and artisans dropped from 74.9 percent to 0.1 percent. Landowners, merchants, and "kulaks" disappeared altogether.¹²

Even allowing for the vagueness and inaccuracy of official Soviet statistics, these figures signify the emergence of an industrialized society, in which tens of millions of factory and office workers had to master the habits of Krupskaya's "planned work." The struggle for labor and productive efficiency goes on unabated. In a speech on Soviet agriculture early in 1965, the secretary of the Communist Party, L. I. Brezhnev, de-

clared that the most satisfying and most noble undertaking is "to build a new discipline of labor, new forms of social relationships among people, new ways and methods of involving people in work. . . ."¹³

The essays in the Redl volume¹⁴ clearly reveal that there is a tension between those educators who want to stress classic academic excellence in schooling and those who believe that the emphasis of the 1930's on academic preparation for work has been carried too far and now requires basic revision ("Our moral education leans more on words than deeds, and we use too few opportunities for socially meaningful work"). Thus, we have the reforms of the late 1950's, in part the push to develop the boarding school, "polytechnical" training, and the refurbishing of Lenin's slogan, "Let work and life be united," as applied to the schools.

Many of the essayists in the Redl collection have a penchant for flights of fancy on the beatitude that will prevail under the "new Communist future." In doing this, they sometimes give away the present: "Nervousness and irritability which our generation acquired during the war years will disappear." One surmises that a vast terrain, unknown to most of us, lies hidden beneath that sentence.

In a similar way, A. G. Kharchev, in a discussion of the future family in Soviet society, discusses the importance of the *internat*, but then passes on the following interesting information as a reminder to his readers:

It should be remembered that, as a result of war, the number of unwed mothers increased considerably. Thousands of children grew up fatherless. Though in principle the morals of communism are opposed to illicit relationships between men and women, these women cannot be judged harshly, since in the majority of cases their action did not stem from personal moral inadequacies but was a result of the tremendous decrease of male population during the war years in our country. Many unwed mothers are in great need of moral as well as economic support, which the community must give them. School internats for their children become one of the most important forms of help extended to them.

Sex Education

The enlightened Victorian approach to childhood and family life, so often remarked on by students of Soviet society, is strongly conveyed by T. S.

Atarov's essay on sex education, published in 1959, and thus fairly up to date as a reflection of the Russian viewpoint.

Since the October Revolution, declares Atarov, "family and marriage constitute the foundation of socialist existence," and citizens must be brought up to lead a morally and spiritually clean sex life and to understand the "true meaning of love." Sex education must be given naturally but sparingly. If the child asks too much, he must be "distracted." Foul language is a temptation to moral and sexual impurity and must be combated everywhere ("everyone must participate in the fight to keep our language clean") and public opinion, apparently somewhat lax in this regard, must be mobilized sternly. So also must public opinion be consolidated in the fight against alcoholism "which is also a fight for a normal sexual life."

The socialist battle against onanism is presumably being won, according to Atarov, but there is yet a way to go. Masturbation in children can be caused by hands under blankets, crawling or lying on the stomach, cynical conversations, observing sex life of animals, and isolation from the collective life. Children must be encouraged to be active in sports, to sleep on hard beds, and never to keep their hands under the blanket. Girls must also be careful when riding bicycles ("the edge of the saddle should not protrude between the vaginal lips . . .").

Advice to Parents

The writers in the "advice to parents" category have much to say that will be familiar to Americans concerned with parent education. In addition to the constant appeals to high morality, duty, conscience, honor, human dignity, love, and friendship, there is much stress on the need for consistency between school and home and the adults within the home, the dangers of casting the father in the role of the disciplinarian, the evils of corporal punishment ("physical punishment . . . is absolutely against the principles of Soviet education"), and the need to maintain individuality of tastes and high esthetic standards ("one cannot visualize Communist living as a poorly run rest home with a uniform menu").

There is the familiar commandment that parents should seek a golden mean between strictness and permissiveness,

Extreme theories about letting the child do anything he wants must be rejected:

There is a pedagogical point of view which believes in the so-called method of trial and error . . . if the child wants to touch the hot samovar, one should not try to stop him. He will burn himself and discover his error. . . . This point of view is fallacious. . . . The school and parent must guide the children, take all measures to prevent unruliness of children, fight disorganization with a pedagogically sound approach, and undertake measures of reward or punishment as needed.

On the other hand, too much laying down of the law, too much nagging is futile: "The great physiologist Pavlov showed that when the very same stimulus constantly hits upon the same brain cells, they are no longer irritated, and cease to react."

Perhaps none of the sources quoted in this review, or of the many not reviewed here which were published prior to 1960,¹⁴⁻¹⁶ gives us a clear perspective on the actual cultural ingredients in the adult-child interaction across the vast expanse of rapidly evolving Soviet society. That is too much to expect of any single effort.

But these volumes certainly do make clear that, despite the many ways in which American and Soviet child-care practices differ, there is at least one

kind of debate which is being conducted within similar terms in both societies: namely, the constructive debate on how we conserve and foster man's profoundest spiritual needs while at the same time making our headlong flight into the new world of breathtaking innovations and supertechnology.

Not all Soviet theoreticians or educators are as obsessed with sputnik as we might think. Perhaps the last word—which is at the same time the opening word—belongs to S. A. Shmakov from his essay "To Inspire Children" in the Redl volume:

To educate an individual, to develop his character and formulate his convictions is much more important than building cities, developing new machinery, and sending rockets into the cosmos.

¹ Marx, Karl; Engels, Friedrich: *The Communist Manifesto*, Washington Square Press, New York, 1964.

² Kharchev, A. G.: *Motives of marriages in the U.S.S.R.* *Acta Sociologica*, vol. 8, fasc. 1-2, 1964.

³ Bowen, James: *Soviet education—Anton Makarenko and the years of experiment*, University of Wisconsin Press, Madison, 1962.

⁴ Makarenko, A. S.: *A book for parents* (trans. Robert Daglish), Foreign Languages Publishing House, Moscow, 1960.

⁵ Weeks, Albert L., Jr.: *The boarding school, Surrey*, July 1965.

⁶ Alt, Herschel; Alt, Edith: *Russia's children: a first report on child welfare in the Soviet Union*, Bookman Associates, New York, 1959.

⁷ ———: *The new Soviet man: his upbringing and character development*, Bookman Associates, New York, 1964.

⁸ Skolnick, Alec: *Some psychiatric aspects of the "new Soviet child."* *Bulletin of the Menninger Clinic*, May 1964.

⁹ Kassof, Allen: *The Soviet youth program: regimentation and rebellion*, Harvard University Press, Cambridge, Mass., 1965.

¹⁰ Grant, Nigel: *Soviet education*, Penguin Books, Baltimore, Md., 1964.

¹¹ Redl, Helen B. (ed. and trans.): *Soviet educators on Soviet education*, The Free Press of Glencoe, Collier-Macmillan, London, 1964.

¹² A state of all the people. *Pravda*, Dec. 6, 1964.

¹³ *Pravda*, Mar. 27, 1965.

¹⁴ Inkeles, Alex; Bauer, Raymond A.: *The Soviet citizen*, Harvard University Press, Cambridge, Mass., 1959.

¹⁵ Levin, Deana: *Soviet education today*, John DeGraff, New York, 1959.

¹⁶ Simon, Brian (ed.): *Psychology in the Soviet Union*, Stanford University Press, Stanford, Calif., 1957.

BOOK NOTES

PSYCHOSOMATIC DISORDERS IN ADOLESCENTS AND YOUNG ADULTS: Proceedings of a conference held by the Society of Psychosomatic Research in London (November 1960). Edited by John Hambling and Philip Hopkins. A Pergamon Press Book, The Macmillan Co., New York, 1965. 246 pp. \$8.50.

According to the editors, the purposes of the 3-day conference reported in this book were two: (1) to "consider psychosomatic disorders occurring between the ages of 15-25 years" and (2) to "discuss the mental transformation from childhood to adult maturity." The participants, for the most part physicians, included general practitioners, gynecologists, obstetricians, pediatri-

cians, psychiatrists, and psychoanalysts.

The book includes 17 papers presented in the conference's first 7 sessions, the ensuing discussions, as well as the comments made by 12 participants in a summing-up session.

The content proceeds from a focus on concepts of mental health and psychosexual development in adolescence, and the present-day social factors impinging on this, through consideration of the psychosomatic factors in specific physical states—pregnancy, menstruation, and specific illnesses, such as tuberculosis and acute appendicitis—to discussion of the "fitness" of today's youth to assume the obligations of maturity.

In the preface the editors issue a warning: "The passage of time will no

doubt prove some of our conclusions to be of historical interest only, for our concepts and values are likely to be more culturally bound than we know. Perhaps in our very demands of maturity we are asking a price of human nature that will have to be paid in psychosomatic disorder."

CRISIS INTERVENTION: selected readings. Edited by Howard J. Parad. Foreword by Lucille N. Austin. Family Service Association of America, New York, 1965. 368 pp. \$4.50.

The purpose of this collection of 29 articles, according to the editor, is to make available the "observations, theoretical explorations, and formal investigations of . . . practitioners and researchers who have addressed themselves to various aspects of crisis intervention." Warning that crisis intervention "is in a fair way of becoming

a fad," with oversimplified concepts and unrealistic expectations, he offers the volume as a collection of readings that "reveals the rich complexity and promise of the material" and may whet the appetite of the reader for more knowledge of the subject.

The 29 articles are grouped under the headings of theoretical explorations, common maturational and situational crises, clinical applications, and the measurement of crisis phenomena. Practically all the articles, dealing as they do with the family constellation in relation to crisis situations, touch in some way on the lives of children, and five articles specifically focus on children: "Social Work in a Preventive Program of Maternal and Child Health" (Florence E. Cyr and Shirley H. Wattenberg); "Kindergarten Entry: A Study of Role Transition" (Donald C. Klein and Ann Ross); "Short-Term Therapy with Adolescents" (Lovick C. Miller); "Children at Risk" (Elizabeth E. Irvine); and "Death Anxiety in Children with a Fatal Illness" (James R. Morrissey).

TEACHING THE TROUBLED CHILD. George T. Donahue and Sol Nictern. The Free Press, New York, 1965. 202 pp. \$5.95.

In support of the argument that "the half-million seriously disturbed children [in the United States today who are] the victims of congenital defect, brain damage, or personality disturbance" can achieve their maximum educational potential within the regular school system if appropriate help is provided, the authors devote the bulk of their book to a description of a project undertaken in 1959 in Elmont, N.Y. In this community the school system received the help of community groups in setting up special classes and adding 74 "teacher-moms" (women who have successfully reared healthy children) to the team of educators, psychiatrists, and psychologists concerned with emotionally disturbed children. Working under professional supervision, the teacher-moms supplement the work of the classroom teacher in a one-to-one teaching relationship.

Of the 31 children who were included in the Elmont project in the first 6 years of its operation, 21 have been returned to regular classes. The authors attribute much of the project's success

to the teacher-mom's ability, through the development of an affective relationship, to give the children successful experiences in functioning, to the point where they began reaching out for new experiences.

MANAGEMENT OF EMOTIONAL PROBLEMS OF CHILDREN AND ADOLESCENTS. A. H. Chapman, M.D., J. B. Lippincott Co., Philadelphia, Pa., 1965. 315 pp. \$9.50.

Written for general practitioners and pediatricians, this book offers physicians advice on detection and management of childhood emotional problems which may lead to mental illness. It stresses throughout the importance of "the three L's: *loss, limitation, and let them grow up.*" Part I focuses on the emotional needs of healthy children and the management of the normal adjustment problems of childhood and adolescence. It contains a special chapter on the problems of children whose parents are divorced.

Part II surveys the emotional disorders of childhood and suggests methods of management. It includes discussions of behavior problems, speech and learning disorders, psychosomatic illnesses, brain disorders, and the emotional problems of mentally retarded children.

Part III describes techniques for evaluating the child's problems and for counseling the parents and the child.

Part IV outlines the nature of psychiatric treatment available to emotionally disturbed and psychotic children.

READINGS IN THE ADMINISTRATION OF INSTITUTIONS FOR DELINQUENT YOUTH. Compiled and edited by William E. Amos and Raymond L. Manella. Charles C. Thomas, Springfield, Ill., 1965. 212 pp. \$7.75.

The 17 articles in this volume, all bearing upon the day-to-day operation of institutions serving delinquent children, are designed to assist individuals or organizations responsible for planning and administering institutions for juvenile offenders removed from the community by the courts.

The first article, "The Philosophy and Purpose of Institutions Serving Delinquent Children," by William E. Amos, one of the editors, is a general discussion of the mission of the modern

treatment oriented institution. It points out that, in 1962, about 65,000 arrested juveniles were committed to institutions. It then traces the historical development of the function of juvenile institutions from 1790 to the present, concluding that the aim of such institutions today is "the alleviation of symptoms and removal or modification of those forces, factors, or conditions which produce the delinquent act."

Chapters follow on the administrative structure of institutions, institutional committees, training, physical plant design, reception-orientation, cottage life, clinical services, reeration, food, clothing, and religious programs.

The final four chapters deal with the special problems of programming for the exceptional child; discipline and security; prerelease planning; and relationships between State agencies and juvenile institutions.

THE GIFTS THEY BRING: our debt to the mentally retarded. Pearl S. Buck and Gweneth T. Zarfoss. The John Day Co., New York, 1965. 156 pp. \$4.50.

In the preface of this book, the authors say that its purpose is to supply evidence lacking in the literature that "the retarded have influenced our present activities and way of life." They proceed in the text to point to advantages to families and communities in assuming responsibility for retarded children; for parents "and their other children," an increased perception from their experience in loving a retarded child; and for the community, "remarkable results in benefits for so-called normal individuals." Among the latter they cite the results of research into fetal development, the measurement of mental abilities, and methods of learning undertaken out of a concern for the prevention and mitigation of retardation; and advances in community cooperation, understanding, and the development of leadership made as a result of concerted community and national efforts for mentally retarded children.

Taking the position that retarded children, whenever possible, should be kept within the family, the authors conclude: "It is not too much to say that what one family does with and for its retarded child in time may change the world."

AMONG THE STATES

The legislatures of every State met either in regular or special session during 1965 and had adjourned by late September, except for those of five States—*Kentucky, Massachusetts, New Jersey, Pennsylvania, and Wisconsin*—which had recessed pending fall sessions or were still in session. Among the many actions taken affecting children were those concerned with:

Mental Retardation

New laws requiring or permitting the testing of infants for phenylketonuria were passed in 24 States, thus bringing to 32 the total number of States with such laws, 25 of which are mandatory and 7 permissive. Laws relating to such tests were already on the books in *Illinois, Indiana, and Oregon*, where they underwent some revision this year, and in *Louisiana, Massachusetts, New Jersey, New York, and Rhode Island*. The States with new laws are: *Alabama, Alaska, California, Colorado, Connecticut, Florida, Hawaii, Idaho, Iowa, Kansas, Maine, Maryland, Michigan, Minnesota, Missouri, Montana, New Hampshire, Ohio, Oklahoma, Pennsylvania, South Carolina, Texas, Utah, and West Virginia*. Legislation to this effect was pending in *Wisconsin*.

Admission requirements to facilities were revised in *New Jersey, New Mexico, and Tennessee* to allow for voluntary admission of children to State mental hospitals or institutions for the retarded; and in *Oregon* to allow for the admission of mentally retarded persons of any age to State-supported group care homes, previously limited to children under 18.

Michigan and *Tennessee* also made provision for relieving parents of financial responsibility for hospitalization of a mentally retarded child after he reaches the age of 21.

The establishment of publicly supported regional diagnostic and counseling centers or clinics for the mentally retarded was authorized in *California* and in *Missouri*. The California Legislature also created a Mental Retardation Programs and Standards Advisory Board; established an office of coordi-

nator of mental retardation programs; and made permanent a pilot child-care program for physically handicapped and mentally retarded children.

Laws providing for facilities or services for the mentally ill or retarded were also enacted in *Minnesota*, where funds were appropriated to rehabilitate a building for a project to train mentally retarded adolescents not admitted to special classes in local schools and for the establishment of new community mental health centers; in *New Hampshire*, where financial support was increased for community mental health centers, and for the education of mentally, emotionally, and physically handicapped children; in *New Mexico*, where the establishment of programs for trainable retarded children in public schools was authorized; in *North Dakota*, where cities and counties with populations of 5,000 or more were authorized to establish mental health and retardation services upon petition of 8 percent of their voters; and in *Utah*, where provision was made for the inclusion of community mental health centers and facilities for the diagnosis and treatment of mental retardation in a hospital construction program.

Day-care programs for mentally retarded children were authorized in *Kansas*, with State funds to be disbursed by the State Department of Social Welfare; and in *Minnesota*, through the levying of city taxes. In *Connecticut*, the State Department of Health was authorized to make grants to nonprofit organizations and hospitals for day-care programs for emotionally disturbed and mentally ill children.

Reorganization of administrative structure for the care of the mentally ill and mentally retarded occurred through legislation enacted in *Alabama* and *Texas*, each with a new department established with responsibility for State mental hospitals and institutions for the retarded: the Alabama State Department of Mental Health, and the Texas Department of Mental Health and Mental Retardation.

In *Iowa*, the legislature codified the

laws regarding treatment, training, instruction, care, rehabilitation, and support of the mentally retarded.

In *Maine*, a statewide Committee on Problems of the Mentally Retarded was authorized to continue functioning.

In *Montana* and *Utah*, the State health departments were empowered to license and supervise facilities devoted to diagnosis, treatment, and care of persons suffering from mental disease or mental retardation.

Health Services

Definitions of "crippled children" in laws providing services to crippled children were broadened in a few States. In *Idaho* and *Montana*, broadened definitions permit children with cystic fibrosis to receive services through the State crippled children's programs, thus bringing to 37 the number of States (including the *Virgin Islands*) which serve children with this condition through their crippled children's programs. In *Kansas*, the legislature authorized services to children with cystic fibrosis through the health department's maternal and child health program. In *Kansas* and *Texas*, broadened definitions of "crippled children" now allow State crippled children's services to be extended to mentally retarded children, previously explicitly excluded.

Services to handicapped children also received attention in *California*, where the State Department of Public Health has been directed to determine the need for residential care of handicapped persons of normal mentality; in *Michigan*, where the once independent State Crippled Children Commission was transferred to the State Department of Health; and in *Missouri*, where the legislature created a coordinating committee for the handicapped.

Tuberculosis testing was made a legal requirement for school entrance in *Kansas* and *Michigan*; and in *Kansas* measles immunization was also made a requirement.

In *Washington*, the legislature appropriated \$20,000 to the University of Washington School of Medicine to continue a study started in 1963 to determine the cause of sudden and unexplained deaths of infants.

State standard-setting or licensing responsibilities for health services were extended in *Illinois*, where the legislature permitted the State Department

of Public Health to categorize local health departments on the basis of current programs; in *New York*, where the State commissioner of health was made responsible for setting standards for care and facilities in all hospitals and nursing homes in that State; and in *Texas*, where the legislature provided for the licensing of maternity homes.

Drinking, smoking, and glue-sniffing among teenagers were the targets of legislation: in *California*, where the State Board of Education was directed to include material on the health hazards of tobacco in textbooks and teachers' manuals, and where controls were put on the sale of toluene and any glue or cement containing substances with similar toxic qualities; and in *Ohio*, where \$91,000 of State liquor fees were earmarked for the State Department of Health to conduct an educational program on problems of drinking.

Family Planning

A number of States authorized the operation of family planning programs under public auspices. In *California* and *Michigan*, the legislatures directed that family planning services be included in public health programs for persons who voluntarily seek such services; and in *California*, a previous penalty for disseminating information about birth control for public health education was eliminated. In *Kansas*, the State Department of Health was directed to operate family planning clinics; *Colorado*, *Illinois*, *Iowa*, and *Nevada* authorized family planning services to be extended to recipients of public assistance; and *Oregon* earmarked funds in its public welfare appropriation for the purchase of contraceptive drugs and equipment.

In *Minnesota* and *New York*, laws were passed permitting the sale of contraceptives.

Adoptions

Laws affecting adoption were enacted or amended in the following States:

California, where the legislature permitted a public child-care or adoption agency to institute action to declare a child free from custody and control of his parents; provided for the confidentiality of records, private hearings, right to counsel, and procedures to inform the parties in proceedings for termination of parental custody; eli-

minated the necessity of getting consent to adoption from a child's father if he has not supported the child for a year or from the mother of a child in an agency's care if she has not been heard from for a year; increased the fee which counties may charge for adoption services to a maximum of \$500; and provided that an adopted child and his adoptive parents shall have the legal relationship of parent and child, with all the rights and duties thereof.

Georgia, where the legislature permitted courts to provide for confidential handling of birth certificates after adoption is decreed; and allowed for the place of birth of an adopted child to be named either as the actual county of birth or the county in which the adoptive parents reside.

Hawaii, where measures were passed to protect those providing medical care for children placed for adoption from unwarranted suits by legal parents.

Indiana, where the Welfare Act was amended to permit county welfare departments to charge a fee of not more than \$300 for an adoption placement.

Minnesota, where the legislature exempted from a statute prohibiting the importation of children into the State, children brought in by relatives intending to adopt them or provide them with foster care; made it unnecessary for identifying information about a child and his natural parents to be filed in an adoption petition involving a placement by an authorized adoption agency; permitted the guardian of a child born out of wedlock, or the child himself after he is 21, to obtain a certified copy of his birth certificate without the necessity of a court order.

Nebraska, where the legislature defined procedures for a legal consent to adoption and for relinquishment of the child.

Nevada, where the adoption law was revised to require a preplacement study of adoptive homes by an authorized agency in all unrelated independent adoptions.

Oklahoma, where new legislation makes the State the 12th to require termination of parental rights by judicial action, and the 25th with penalties established for black market adoption placements. (Such penalties have also been provided for in the *District of Columbia*.)

Oregon, where provision was made for the petitioner for adoption, or

"some other suitable person," to be appointed guardian of a minor while adoption is pending.

Texas, where the legislature added new safeguards to protect the confidentiality of adoption records; and permitted licensed child placing and adoption agencies to charge reasonable fees for social services.

Utah, where the legislature made it optional rather than mandatory for the kindred of a child deserted by his parents to be notified of adoption proceedings; permitted adoption of a child by stepparent without an investigating report by the State Department of Public Welfare; and permitted any authorized or licensed children's agency to release its control and custody of a child to another licensed agency.

West Virginia, where the legislature permitted revocation, within 10 days after a child's birth, of parental consent for adoption, or relinquishment of legal custody, given before the child was 72 hours old.

Family and Juvenile Courts

In a number of States—*Hawaii*, *Illinois*, *North Carolina*, *North Dakota*, *Utah*, and *Vermont*—the legislatures established new courts or reorganized their State court systems.

In *Hawaii*, a new statewide family court will process cases involving divorce, separations, annulments, non-support, child custody, adoptions, neglect, and juvenile delinquency; and will have exclusive jurisdiction in cases of law violations involving offenders under 18 and concurrent jurisdiction with the criminal court in cases involving minors (under 20) who are already under a family court order.

In *Illinois*, juvenile court procedures were revised through a new juvenile court act which also provides for probation, social services, and psychiatric personnel and authorizes counties to levy a tax in connection therewith.

In *North Carolina*, children's cases, except for adoptions, were put under the jurisdiction of the district court and provided full-time judges; adoption cases remain under the clerk of the superior court.

In *North Dakota*, family courts were established as divisions of district courts.

In *Utah*, the juvenile court was separated from the State Department of Public Welfare and established as a

statewide court at the district court level, with a Juvenile Court Commission; the judges to be appointed by the Commission.

In *Vermont*, a district court system was created to replace municipal courts.

The ages of children subject to juvenile court jurisdiction were changed in a number of States: *Arkansas*, where the maximum age was lowered from 21 to 18; *Kansas*, where it was raised to 18; *New Hampshire*, where it was lowered from 18 to 17; and *Texas*, where it was set for girls at 18, and for boys at 17, with the courts being given permission to transfer young people of 16 or over to other courts if the offense would be a felony if committed by an adult or if the court deems it to be in the best interest of the child.

The *Arkansas* Legislature also provided that any referee appointed by the juvenile court shall have power to hear and pass on juvenile cases.

Juvenile court laws were also amended in *Alabama*, to require juvenile court probation staff in certain counties to be certified by the Department of Pensions and Security; in *Iowa*, to recodify the courts' functions and procedures and specify State and county welfare departments as agencies available to them for assistance in rehabilitating families and children; in *Kansas*, to provide for commitment of dependent or neglected children to the county only if parental rights are not severed; in *Nebraska*, to permit minors to be released on bail, and to prohibit the detention of minors in jails or police stations; in *Oklahoma*, to require a county or juvenile judge to have a complete case history of each juvenile brought before the court as delinquent; and in *Oregon*, to include untreated illnesses as a criterion for bringing children under the jurisdiction of the juvenile court as dependent and neglected.

Support

Laws to enforce support from fathers of children receiving public assistance were passed in *New Mexico*, where the State Department of Public Welfare was authorized to bring court action; and in *Texas* where the welfare department was empowered, through the enactment of a Uniform Reciprocal Enforcement of Support Act, to join with other States to obtain support from fathers.

In *Illinois*, the Department of Children and Family Services was empow-

ered to take legal action against parents or guardians who refuse to make the payments due the department for their children's care.

In *Utah*, the legislature made fathers as liable for the support of a child born out of wedlock as for a child born in wedlock; and established procedures to determine paternity.

Interstate Compacts

Iowa, *Kansas*, *Texas*, and *Wyoming* entered the Interstate Compact on Juveniles, bringing to 41 the number of States which have joined this compact for returning adjudicated juvenile delinquents to their home States.

New Hampshire entered the Interstate Compact on Placement of Children, bringing to 8 the number of States in this agreement for providing services to protect children placed in foster care across State lines. (Legislation to this effect was pending in *Pennsylvania*.)

Protection and Welfare

Twenty-six States passed new laws requiring or encouraging the reporting of suspected child abuse, thereby leaving *Hawaii*, *Mississippi*, and *Virginia* as the only States without such laws. Of the 47 States with such legislation, 41 have mandatory reporting laws, while 6 have permissive laws designed to encourage reporting by providing immunity from liability for persons reporting under the statute.

In *Connecticut*, the commissioner of the State Welfare Department was authorized to furnish protective services for neglected or abused children, and a penalty was provided for unauthorized removal of a committed child from a foster home. In *Georgia*, penalties for child abandonment were increased; and the Department of Family and Children Services was appropriated funds to establish six diagnostic and treatment centers for children referred by juvenile courts.

Protections for children in divorce were provided in *Hawaii*, where interlocutory decrees in cases involving children were made mandatory.

Seven States—*Maine*, *Maryland*, *Massachusetts*, *Montana*, *Nevada*, *New Hampshire*, and *South Dakota*—passed laws requiring the licensing of facilities for the day care of children, thus bringing to 49 the number of States (including the *District of Columbia*, *Puerto Rico*, and the *Virgin Islands*)

requiring licensing of day-care centers or family day-care homes, or both types of arrangements.

In *Illinois*, the State Department of Children and Family Services was authorized to license facilities for child care according to three classifications based on the presence or absence of casework and diagnostic and treatment service.

In *Illinois*, agricultural labor camps operating less than 3 weeks, formerly exempted from health department licensing, were brought under the licensing requirements; and in *Michigan*, all agricultural labor camps became subject to licensing by the State Department of Health.

Provisions to permit State welfare departments to purchase care for children in their charge from licensed children's institutions or licensed or approved foster-family homes were made in *Kansas* and *Montana*; and in *Oregon*, \$1 million was appropriated for purchasing care from private child-care institutions.

In *Indiana*, the Juvenile Court Act was amended to allow for increased per diem payments for foster care of children, to \$4 for boarding home care and \$6 for care in county-operated child caring institutions, and eliminated the per diem limit for care in a private institution.

In *Iowa*, the State Board of Control in cooperation with the State Conservation Commission was authorized to select boys from the State training schools for work in State parks, preserves, and other State-owned lands.

In *West Virginia*, the legislature transferred responsibility for juvenile parole supervision from the Department of Welfare to a new Division of Corrections in the Office of the Commissioner of Public Institutions.

Public Assistance

Ten States enacted legislation to extend the eligibility age to 21 in the program of aid to families with dependent children for children who are successfully pursuing a course of study or training: *California*, *Maine*, *Montana*, *New York*, *North Carolina*, *North Dakota*, *Ohio*, *Tennessee*, *Washington* and *Wyoming*. Two other States also extended the AFDC age of eligibility for children successfully pursuing a course of study or education: *Louisiana* to age 19; and *Iowa*, to age 20.

In *Texas*, the legislature proposed a constitutional amendment which would extend the eligibility age for children in the AFDC program to 21 and would authorize medical care for "needy children and the caretakers of such children."

Nebraska and *Wyoming* were authorized to extend their Federal-State public assistance programs to children of unemployed parents, thus bringing to 24 the number of States with such authority. (Similar bills were still pending in *New Jersey* and *Wisconsin*.)

In *Connecticut*, *Iowa*, and *Wyoming*, the State welfare departments were authorized to make payments for foster

care for children in the AFDC program who are living with nonrelatives.

Maine eliminated its residence requirements for eligibility to public assistance.

Studies and Structure

Special studies were ordered by the legislatures of *Arkansas*, *Illinois*, *New York*, and *Vermont*: a study by the Arkansas Legislative Council of the feasibility of placing the State's four training schools for delinquents under a central authority; a 2-year study of public health by an Illinois legislative commission established for the purpose; a study of child-care needs and services

in New York by a joint legislative committee on child-care needs; a study of social welfare problems by the Vermont Legislative Council.

State committees on children and youth were authorized to continue functioning in *Maine* and *New Mexico*; and in *North Dakota*, the Committee on Children and Youth was made part of a newly established Governor's Council on Human Resources.

In *Colorado*, the child welfare division in the State Department of Public Welfare was renamed the Division of Children and Youth.

—Jean Lang

FILMS ON CHILD LIFE

Charges for rental or purchase, not given because they change, may be obtained from distributors.

INCIDENT IN WILSON STREET. 51 minutes; sound; black and white; rent or purchase.

This film shows the interacting responses of fellow pupils, teachers, the principal, and a father to an "incident" created in an elementary school class by a young girl with a physical handicap (cleft palate). Provides insight, through this example, into the problems of emotionally disturbed children and how to help them.

Audience: Inservice and preservice social workers, mental health specialists, teachers, churches, and intergroup organizations.

Produced by: McGraw-Hill Text-Films.

Distributed by: McGraw-Hill Text-Films, 330 West 42d Street, New York, 10006.

CHILDREN AT PLAY WITH POISON. 10 minutes; color; sound; purchase or loan.

An animated cartoon with three children as the principal characters, this film points up the hazards of poisons in the home and stresses the need for precautionary measures to protect children from serious or fatal injury.

Audience: Parents, safety clubs, semiprofessional groups interested in safety, community organizations, and public health agencies.

Produced by: Creative Arts Studio for the Public Health Service, U.S. Department of Health, Education, and Welfare.

Distributed by: Creative Arts Studio, Inc., 814 H Street NW, Washington, D.C. For loan from the National Medical Audiovisual Facility, Atlanta, Ga., 30333.

HIGHLIGHTS OF THE 1965 WHITE HOUSE CONFERENCE ON EDUCATION. 20 minutes (35 mm. film-strip with 32 ips and printed script); color; purchase.

Presents some of the highlights of the 1965 White House Conference on Education, July 20-21, and illustrates some of the major issues discussed. The script gives excerpts of the statements of some of the speakers including President Johnson, Vice President Humphrey, and John Gardner, now Secretary of Health, Education, and Welfare, and of panelists and audience members, with continuity narrated by news commentator Howard K. Smith.

Audience: General public, student-teachers, teachers, school administrators, school boards, PTA's, and legislators.

Produced by: Publications Division, National Education Association.

Distributed by: National Education Association, Publications-Sales Section, 1201 Sixteenth Street NW, Washington, D.C., 20036.

AUDITORY SCREENING FOR INFANTS. 15 minutes; sound; color; purchase, rent, or loan.

Emphasizes inclusion of an auditory test in the routine examination of infants from 8 to 10 months old, using a 2-minute screening method known as the distraction technique. The first part of the film shows the responses of 6 infants 24 hours to 6 month old to stimuli found in a baby's world, calibrated for sound frequency and intensity; the second part depicts the application of the distraction technique to 4 infants 8 to 10 months old and shows their reactions.

Audience: Physicians; nurses; health departments and medical and nursing schools; schools of public health; and speech and hearing centers.

Produced by: Child Growth and Development Study, Johns Hopkins University; and the Division of Maternal and Child Health, Maryland State Department of Health.

Distributed by: Bureau of Preventive Medicine, Maryland State Department of Health, 301 West Preston Street, Baltimore, Md., 21201.

HERE AND THERE

Homemaker Services

Five hundred people from 19 countries attended the International Congress of Homemaking Services, held in Königstein/Tannus, Federal Republic of Germany, September 8-11, 1965, under the auspices of the International Council of Homemaking Services.

With the theme of the Congress, "Homemaking, A Modern Social Profession," a number of speakers—including the U.S. Commissioner of Welfare, Dr. Ellen Winston, and Dr. Rudolf Pense, of Frankfurt/Main, Germany, who summarized the work groups—stressed the place of a homemaker service (or a homemaking service, as it is called in Europe) as a link in the chain of social services needed in every community.

In her address, Dr. Winston described the use of homemakers in this country as part of a homemaker-caseworker team to help deprived families raise their levels of living, by demonstrating methods of home management and child care and by helping the families to make the most of whatever resources are available to them. Ensuing discussions indicated that the collaboration between caseworker and homemaker as well as the teaching and demonstration aspects of homemaker service are further developed in the United States than in many other countries.

On the other hand, reports by representatives of other countries revealed that European countries are far ahead in providing and training homemakers and in the degree to which the service is generally accepted. For instance, a representative of Great Britain, a country with a population of 52.5 million, reported that her country has some 58,000 homemakers. Dr. Winston had said that in the United States, a country with a population of 191 million, about 5,000 homemakers are made available by voluntary and public agencies.

Discussions on training and working conditions—including rates of pay and fringe benefits—indicated that the oc-

cupation of homemaker is regarded in many countries as a respected career for young women who attend schools for special training. An illustration of this was available in the presence of many young women as Congress assistants, all of them students of German schools which train homemakers.

The Council selected Brussels, Belgium, as the setting of the next International Congress, tentatively set for 1969.

Proceedings of a previous congress sponsored by the Council in Paris in 1962 have recently been published in English by the Welfare Administration, U.S. Department of Health, Education, and Welfare. (WA Publication No. 10: 30 cents, from the Superintendent of Documents, U.S. Government Printing Office, Washington, D.C., 20402.)

Professional Training

Sixty-three schools of social work and three other educational institutions were awarded a total of \$3,578,579 in Federal funds through the Children's Bureau in fiscal year ending June 30, 1965, to help train child welfare workers.

The awards—almost double the amount awarded in fiscal year 1964—were the third annual series of child welfare training grants.

Of the total, \$1,799,155 was awarded for 535 traineeships at the master's degree level and 28 traineeships at the doctoral level, the trainees to be selected by the schools; \$1,550,679, for 106 teaching grants, 87 of which will support field instruction units and 19 classroom teachers in child welfare; and \$228,745, for short-term training activities for persons already working in the field of child welfare.

Child Health

Examinations of the dental, eye, and thyroid conditions of 2,000 public school children in Washington County, Utah were begun on September 17, as part of a long-term investigation to determine the effects on child health of radiation received from fallout from nu-

clear tests carried out during the 1950's at the Nevada Test Site. The investigation, which is being conducted jointly by the U.S. Public Health Service, the Nevada State Department of Health and Welfare, and the Utah State Department of Public Health, began in 1959 with a study of leukemia deaths occurring in Nevada and Utah. It was expanded in 1963 to include thyroid and bone cancer and congenital malformations. The attempt is to learn whether there is a statistically meaningful difference between the incidence of these conditions in children in areas which received the greatest fallout and in children elsewhere.

An equal number of school children in Safford, Ariz., are being examined as controls in the current thyroid study.

In addition to examining the children in this study for effects of radiation, scientists are testing, for other purposes, the children's ability to taste or smell certain chemicals. This is part of a scientific effort to accumulate information on the physiological associations related to such abilities, and so to test the theory that the ability to smell specific odors may represent a new set of genetic patterns similar to the human blood groups. According to scientists at the National Institutes of Health, if this theory proves valid, it would be of great value in the study of human genetics.

The New York Service for Orthopedically Handicapped, New York City recently received a 3-year grant of \$180,000 from the National Institute of Mental Health, to study a new method of integrating orthopedically handicapped children into community life through participation in after-school programs at neighborhood centers and settlement houses.

The National Institute of Allergy and Infectious Diseases, Public Health Service, recently awarded to a commercial firm a \$214,000 contract for the development of a vaccine against the respiratory syncytial virus, the most significant single agent responsible for severe and sometimes fatal respiratory disease in infants, especially those under 6 months of age. In their work, the researchers will make use of the Oak Ridge (Tenn.) National Laboratory's "zonal centrifuge," which was developed collaboratively by the National Insti-

tites of Health and the Atomic Energy Commission. The NIAID estimates that development of an effective vaccine against this virus might eliminate many of the annual 10,000 infant deaths attributed to acute respiratory disease, including pneumonia.

Four new leaflets on epilepsy have been issued by The Epilepsy Foundation, 1419 H Street NW, Washington, D.C., 20005: "A Survey of State Laws," "Epilepsy and Insurance," and English and Spanish versions of "Answers to Some of the Most Frequently Asked Questions about Epilepsy."

Copies are available free from the Foundation.

For Youth

Eight persons from seven countries in Africa, Asia, and South America came to this country for 90 days, between August 16 and November 8, 1965, for the second annual seminar on leadership training for youth activities, sponsored by the Children's Bureau in cooperation with the Agency for International Development. The first seminar, held in 1964, was attended by 14 persons from 9 countries.

Each year, the group spent the first 3 weeks in Washington, D.C., attending lectures at the Washington International Center, and observing youth-serving agencies in the area, before going to other cities to observe the activities of similar agencies. This year's group spent 3 weeks in Boston under the supervision of the Boston University Law-Medicine Institute observing local services for youth; a week in New York observing the planning activities of national voluntary agencies; and a week in Pennsylvania under the supervision of the Pennsylvania State Department of Public Welfare observing rural services for youth.

Afterward, the participants were individually assigned to local youth-serving agencies in Michigan, Colorado, New Jersey, Connecticut, and Missouri, where they studied programs with activities applicable to their own countries. Before leaving the United States, they returned to Washington, D.C., for reporting and evaluation.

Twenty-five teenage girls in Raleigh, N.C., completed a course in babysitting last summer, sponsored by the Home Life Department of the Junior Wom-

en's Club of Raleigh. The girls had 14 hours of instruction and 16 hours of supervised babysitting. A pediatrics nurse and staff members of the local chapter of the American Red Cross, the YWCA, and fire and police departments assisted in the project. On completion of the course, each girl received a certificate and a copy of the Children's Bureau publication "When Teenagers Take Care of Children."

The club expects to offer the course again next summer.

Research on Learning

A research and development center for the study of the learning potential of children between the ages of 3 and 12, from all social and economic levels, is being established at the University of Georgia under a 5-year contract with the U.S. Office of Education. The university is to receive about \$3,200,000 in Federal funds for the project over the 5-year period and spend \$1,808,454 of its own funds.

The center will study the limits of learning and attempt to establish new norms for learning; develop and test new curriculum materials that may be helpful to early and continuous intellectual stimulation; and distribute reports of research findings and materials to elementary and secondary school teachers and administrators, with the aim of improving educational practices and policies.

The center will also study the administrative organization of schools; attempt to clarify the role of guidance in the elementary school; and appraise new methods of teaching reading, particularly early reading.

Other research and development centers supported by the U.S. Office of Education are at the University of Wisconsin, Harvard University, the University of Pittsburgh, the University of Oregon, Stanford University, and the University of Texas.

The Toy Manufacturers of the U.S.A., Inc., has made a grant of \$12,000 to Wheelock College, Boston, for a study of early childhood learning, with the aim of finding out how toys aid in the development of children. Concurrently, the American Toy Institute, a research organization receiving support from the toy association, is cooperating on two other projects: a study to measure the usefulness of toys in working with

mentally retarded children; and a study of the use of toys in providing children of lower income, urban families with preschool experience that will enable them to enter regular first-year programs.

Against Delinquency

Encouragement of the wider use of policewomen in police work with juveniles is a major objective of a yearlong series of workshops which got under way last summer under the sponsorship of the International Association of Chiefs of Police. The project is supported by an \$80,014 Federal grant from the Office of Juvenile Delinquency and Youth Development which was made in cooperation with the President's Committee on Juvenile Delinquency and Youth Crime.

Planned to help police departments develop sound procedures for dealing with juveniles, the workshops are bringing together representatives of law enforcement agencies, including policewomen executives, from across the country. They are focusing on the development of training programs and materials for work with juveniles, with emphasis on expanding the functions of policewomen in juvenile work.

The practice in some police departments of assigning policewomen to interview delinquents and make investigations of family circumstances and other factors which may contribute to delinquent behavior is being used by the workshops as a training model.

Several recommendations for dealing with the problem of employers' resistance to hiring young people with police records emerged from a workshop on arrest records and youth employment held in San Francisco last spring, under the sponsorship of the San Francisco Committee on Youth, United Community Fund of San Francisco. Attended by about 80 representatives of business and industry, government agencies, unions, social agencies, and courts, the workshop grew out of difficulties met by the Hunters Point-Bayview Youth Opportunities Center in trying to place newly trained youth in employment. The center, a demonstration project to improve the employability of school dropouts in one of San Francisco's "poverty pockets," has found that 50 percent of its trainees have police records.

After discussions which stressed the wide range of meanings in an arrest record—"from mistaken identity and minor offenses to serious offenses"—and the potential industrial contribution of rehabilitated young people, the conferees urged that:

- The "story" of arrest records and youth employment problems be brought to the attention of employers at the policy level.

- The question on employment applications, "Have you ever been arrested?" be changed to "Have you ever been convicted?"

- Arrest records for minor offenses be sealed after a 1- or 2-year interval instead of the present 5-year interval.

- Employers look to probation and parole officers for help in evaluating potential employees with records of arrest.

- Auto pool-bonding principles be applied to employees with arrest records, to spread the risk among bonding companies.

Mimeographed proceedings of the workshop are available from the United

Community Fund of San Francisco, 2015 Steiner Street, San Francisco, Calif., 94115.

Migrant Children

Twenty-three children of agricultural migrants in Columbia County, Pa., received daytime care in the homes of local families last summer, under the sponsorship of the Pennsylvania State Department of Public Welfare. The children, all Negro children under 3, were the first to be placed in family day care in the Department's 11-year-old program for migrant children supported by Federal child welfare services funds. Approximately 300 other migrant children of all ages were cared for in day-care centers conducted by the Pennsylvania State University, under contract with the Department. Each center contained at least one welfare worker and a teacher qualified in early childhood education.

The pilot projects in family day care were extensions of a day-care center at Bloomsburg. The day-care families, six white and one Negro, were recruited

by the centers' welfare workers and reimbursed by the Department for their child-care services. The Department provided staff to take the children to and from their family day-care homes each day by bus.

In Adams County, Pa., the day-care center for migrant children was conducted last summer in a new building, constructed for the purpose by the local fruit growers association. Plans are to use the building for a community center in nonmigrant seasons.

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Three new health education films for Spanish-American migrant farm families have been released by the Public Health Service: "*Un Lugar mas sano en que Vivir*" ("A Healthier Place to Live"); "*Mantengase Limpio—Conservate su Salud*" ("Keep Clean—Stay Well"); and "*Comida Sana*" ("Safe Food"). They are available in color and in black and white, for loan free of charge from the PIIS Audiovisual Facility, Atlanta, Ga., 30333. The Facility will also supply information about purchase.

Guides and Reports

CASEBOOK AND PROCEEDINGS: SEMINAR ON THE BATTERED CHILD SYNDROME. Community Mental Health Services, Division of Institutional Management, State Department of Social Welfare, Topeka, Kans., 66612. 1965. 69 pp. Copies free on request from Community Mental Health Services, Kansas State Department of Social Welfare.

Includes case histories and papers pointing up the various medical, legal, and social aspects of child abuse, and their meaning for the community's design for coping with the problem.

STANDARDS FOR HOMEMAKER-HOME HEALTH AIDE SERVICES. National Council for Homemaker Services, 1790 Broadway, New York, 10019. 1965. 48 pp. \$1.

Defines principles for organizing and operating a community service to provide homemakers (or health aides)

to families or individuals—whether through an independent agency or a unit of a social or health agency—drawn up by a committee representing 17 national health and welfare agencies.

PUBLIC WELFARE RESPONSIBILITY FOR CHILD PROTECTIVE SERVICES. Children's Division, The American Humane Association, P.O. Box 1266, Denver, Colo., 80201. 1964. 22 pp. 25 cents. Quantity discounts on request.

Three papers discussing the legal, financial, and community problems that hamper the promotion or expansion of protective services for children under public welfare auspices.

RURAL YOUTH IN A CHANGING ENVIRONMENT: Report of the National Conference of Rural Youth in a Changing Environment, at Oklahoma State University, Stillwater,

September 22-23, 1963. Edited by Ruth Cowan Nash. National Committee for Children and Youth, 1145 19th Street NW, Washington, D.C., 20036. 1965. 345 pp. \$2.50 plus 25 cents postage. Discount prices on bulk orders.

Reports on the composition, origin, and focus of the conference, and includes an analysis of a nationwide study of the problems, attitudes, and aspirations of young people in rural areas; full texts and summaries of addresses by Government and State officials, educators, and others; the recommendations; and an appendix with a report of followup activities throughout the Nation.

YOUTH'S SEARCH FOR IDENTITY; a psychiatrist looks at youth work. Alexander Reid Martin, M.D. Boys' Clubs of America, 771 First Avenue, New York, 10017. 1965. 48 pp. \$1.25.

A discussion of ways of helping youth live creatively, both on and off the job.

IN THE JOURNALS

"Personalization" of AFDC

The degree to which the intent of the program of aid to families with dependent children (AFDC) has been achieved is "both a source of gratitude and remorse," says Morris Kagan, writing in the July 1965 issue of the quarterly *Public Welfare*. He expresses the conviction that the AFDC program "will cease to be the scapegoat of public attack when the children served by it become personalized—individual human beings—not tax-supported clients." ("AFDC: A Response to Poverty.")

The author, a visiting associate professor of social work at the University of Texas, points out that the AFDC program had helped many children to rise above poverty and illiteracy by keeping their homes together and making it possible for them to remain in school until the age of 18. The "reported failures" of AFDC, he maintains, have in many instances been due to a "philosophy of helping . . . in terms of dole expenditures rather than problem-solving investments" and a ". . . false economy of parsimony typified by starkly inadequate grants, insufficient number of staff, poorly trained and poorly paid staffs, and large case loads"

After analyzing the economic and democratic bases of the program, the author suggests that the real hope for developing better support for it is to stress its "compassionate value" by moving from "the realm of statistics to the realm of people." "On a depersonalized basis," he states, "the health and welfare of children—the fabric of AFDC—may be attacked," but when the program "is personalized to the public such attacks become increasingly difficult to mount."

New Journal

Southern Education Report, a new bimonthly journal issued by the Southern Education Reporting Service, Nashville, Tenn., made its appearance with a July-August 1965 issue. It replaces the monthly journal *Southern School*

Views. According to the first issue, the new journal will report on programs for expanding educational opportunities for the socially and economically handicapped, primarily in the 17 Southern and border States, and will follow a policy of "factual objectivity and non-advocacy," though seeking "to report evidence of success or failure."

Among the topics discussed in the eight articles of the first issue are: the North Carolina Advancement School; methods for eliminating handicaps to education of the culturally disadvantaged; vocabulary and dialect problems faced by educators of the disadvantaged; the Nashville Education Improvement Project; and the "motivation program" of a St. Louis school district.

The issue also includes a survey of developments in school desegregation and a "box score on school district progress in desegregation, both regular features continued from the *Southern School News*.

Interracial Adoption

Twenty Negro children have been adopted by white families in Minnesota as a result of a 2-year promotion campaign by a committee of Minnesota's adoption agencies, according to an article by Harriet Fricke, case director of the Lutheran Children's Friend Society of Minneapolis, in the July 1965 issue of the quarterly *Social Work*. ("Interracial Adoption: The Little Revolution.") The campaign was begun when the committee, formed to publicize the need for adoption homes for children of minority groups, recognized that Minnesota's small population of Negroes, already adopting at the same rate as the white population, could not absorb the many Negro children awaiting adoption.

The placements were made by 7 of Minnesota's 13 voluntary adoption agencies and by the State Department of Public Welfare in conjunction with several county welfare departments.

The project was promoted through news stories about white applicants for Negro children, speeches to groups,

and talks with individual persons. The committee selected as its targets the "room for one more" families—parents who already have children of their own but who are interested in adopting other children "because they know children need them."

Some of the unfavorable initial responses to the campaign the author describes as the "I'm not prejudiced—but everyone else is" attitude, and the "but what about discrimination?" position, especially in regard to the question, "What will happen when the child is ready for dating?" She reports that the "straddling position" of some social workers, noted by "astute applicants and community leaders," proved damaging to "the much-sought after positive professional image."

Nevertheless, the committee found that community readiness was at a higher level than "even the most hopeful of hopefuls had anticipated."

Semianual to Quarterly

The British periodical, *Journal of Mental Deficiency Research*, became a quarterly instead of a semianual publication with its March 1965 issue. The National Association of Retarded Children (New York) has made the change possible by a grant of \$4,000 to meet the additional cost of publication. With a few exceptions, the journal publishes only reports of original research of interest to pediatricians, geneticists, psychologists, psychiatrists, and neurologists. Begun in 1957, it is published by the National Society for Mentally Handicapped Children, 5 Bulstrode Street, London, W.1, England.

Overcoming Cleanliness

How the use of Montessori methods helped severely retarded children overcome an exaggerated fear of getting dirty, is described by Lena L. Gitter, a consultant of the American Montessori Society, in the July 1965 issue of the *Bulletin of Art Therapy*. ("Montessori and the Compulsive Cleanliness of Severely Retarded Children.") Such a fear, the author reports, is common among retarded children whose parents have used severe methods of toilet training and often prevents the child from taking part in activities requiring self-expression. This fear was so strong, she says, among some of the children who attended the Hillcrest Heights Special Center in Prince

Georges County, Md., that the teachers could not persuade the children to play with water, use a paint brush, or even pick up a crayon.

The staff used the Montessori principle of teaching children nonfrustrating preliminary activities to prepare them for activities involved in the ultimate

learning goal. The children were given such unmessy occupations as pouring dried beans (instead of water), picking the beans up (with the same fingers used in holding a crayon), and arranging geometric metal shapes and varicolored chips of wood—tasks chosen to prepare their muscles and eyes for the

use of art materials and to stimulate their interest in creating images. By the end of the year, the author reports, most of the children were "painting happily" and had lost their compulsive fear of making a mess. Spilling something, which had once sent them into tantrums, merely sent them for the mop.

READERS' EXCHANGE

HESS-SHIPMAN: *Room for all*

The interesting paper by Robert D. Hess and Virginia Shipman, in the September-October 1965 issue of CHILDREN ["Early Blocks to Children's Learning"], has the merit of bringing out concretely how class differences in the mother-child relationship influence later intelligence and cognitive styles.

Basil Bernstein's distinction, referred to in the article, between "status-oriented" families, wherein norms of behavior are demanded by fiat, and "person-oriented" families, wherein behavioral norms may be modified by the unique characteristics of the child as well as by preferences and situational factors, reminds one of the Baldwin-Kalhorn-Breeze distinction between "warm-democratic families" and "autocratic families," perhaps also "warm." The warm-democratic families made decisions which took into account the wishes of all and the possible consequences, which were spelled out for the children. The autocratic families demanded obedience without explanation. These investigators found that between 3 and 7 years of age children in the warm-democratic families tended to gain in IQ, while those in the autocratic families tended to lose in IQ.

What is particularly interesting about the Hess-Shipman study is the evidence that differences exist between social classes in the prevalence of such family types, the "status-oriented" being much more common among families of low socioeconomic levels than among the middle classes. Clearly, this documents the theory that accident of birth destroys equality of opportunity for children to maximize their potential.

The implications for corrective pro-

grams drawn by Hess and Shipman look plausible, but only empirical results can determine their validity.

I still suspect that an infant under 6 or 7 months of age in a lower class family may have a richer environment in either a crowded, lower class home or a primitive home than in a middle-class American home, by virtue of the greater variety of stimulation and handling he is apt to receive. The general observation that babies of primitive cultural and lower class backgrounds tend to develop in motor functions earlier than those of middle-class families has recently been reinforced with anthropological reports and social studies.

I also suspect that the advantage of the child in a primitive cultural or lower class home over a middle-class American child ceases just before the end of the first year of life when children begin to be interested in new experiences and to imitate novel actions and vocal patterns. Once a child begins to move under his own power and gets in the way of others, and once he begins to ask such questions as "What's that?" the potential for developmental damage in a primitive or lower class culture begins in earnest.

However, contrary to their contentions, it may be quite enough to focus on language skills in intervention to help these children. Carl Bereiter and his associates at the University of Illinois were able within 6 months to move the language skills, as measured by the Illinois Test of Psycholinguistic Abilities (ITPA), of 4-year-old children selected from the bottom of the opportunity scale by something like 2 years of ITPA-age, with training focused on language and arithmetic skills for 2 hours a day. The training started with

pronunciation, went on to statements of demonstrable and observed relationships (above-below, nearer-farther) in statement form, and then to arithmetic formulated as statements.

One of the interesting consequences of the Bereiter demonstration is the satisfaction the mothers have taken in their children's accomplishments. One of their most common remarks has been: "I could never understand him but now I can."

Whether such training must be supplemented for best results by opportunities for children to initiate and carry out learning projects on their own is an open question, as is the question of how much can be achieved with the talking typewriter.

One cannot base his prescription for intervention entirely on an analysis of the social conditions which create the deficit. At this stage of history, there is room for appropriately testing various hunches about how to intervene

J. McVicker Hunt

Professor of Psychology, Psychological Development Laboratory
University of Illinois, Urbana

BRIELAND: *Wrong impression*

Donald Brieland's article in the May-June 1965 issue of CHILDREN was excellent. ["The Efficient Use of Child Welfare Personnel."] However the section about the teaching materials project of the Council on Social Work Education is a little misleading, since it gives the impression—I am sure unintentionally—that the materials are to be available only to public welfare agencies. Actually, the materials will be available to all agencies—public and private—to graduate schools of social work, and to undergraduate schools offering social welfare content.

E. Elizabeth Glover

Editor of Child Welfare, and Director of Publications, Child Welfare League of America

SOME U.S. GOVERNMENT PUBLICATIONS FOR PROFESSIONAL WORKERS

Publications for which prices are quoted are for sale by the Superintendent of Documents, U.S. Government Printing Office, Washington, D.C., 20402. Orders should be accompanied by payment. Twenty-five percent discount on quantities of 100 or more.

CLINICAL PROGRAMS FOR MENTALLY RETARDED CHILDREN: a listing. Rudolph P. Hormuth, Department of Health, Education, and Welfare, Welfare Administration, Children's Bureau, 1965. 44 pp. Single copies free from the Bureau.

This edition, the sixth, lists by States 139 special clinical facilities for mentally retarded children, including 94 which receive full or partial support through the Children's Bureau.

OPEN HEART SURGERY IN CHILDREN: a study of nursing care. Florence G. Blake, Department of Health, Education, and Welfare, Welfare Administration, Children's Bureau, CB Publication No. 418, 1964. 102 pp. 35 cents.

After describing the methods of studying six children who had been hospitalized for cardiac surgery, this publication presents in detail the case of one of the children, 4-year-old Suzie. It seeks

answers to two questions: how can nursing care minimize the physical hazards, anxieties, fears, and discomforts to which such children are subjected; and what problems require further systematic investigation to protect children's welfare after cardiac surgery? Suggestions for using Suzie's case story as a tool in nursing education are included.

AGENCY OPERATED GROUP HOMES: a casebook. Martin Gula, Department of Health, Education, and Welfare, Welfare Administration, Children's Bureau, 1965. 89 pp. Single copies available from the Bureau without charge.

This casebook lists 5 public welfare agencies and 10 voluntary social agencies which operate 66 community-oriented, group-care facilities for children and adolescents with social and emotional problems; describes the policies, programs, and staff of these facilities; and presents brief discussions of their values and limitations as seen by their administrators. The group-care facil-

ties include: 34 operated by 4 public and 9 voluntary agencies in the United States; 1, by a Canadian voluntary agency; and 31, by the New Zealand public agency, the largest number operated by any single agency.

HEALTH, EDUCATION, AND WELFARE TRENDS, 1961 EDITION: PART I, NATIONAL TRENDS. Department of Health, Education, and Welfare, Office of the Assistant Secretary (for Legislation), Office of Program Analysis, 1965. 122 pp. \$1.

Contains two feature articles, "Major Trends During 1963 Affecting Health, Education, and Welfare" and "Public and Private Expenditures for Health, Education, and Welfare, 1935-1961"; and tabular data and charts furnishing perspective on a variety of long-term developments, including, among other areas, health, manpower and facilities, educational staffing and facilities, earned degrees, books and periodicals, vocational rehabilitants, research and development, family income, government social welfare expenditures, Federal grants-in-aid.

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